

Joint Pharmacy Organisations' Paper for Endorsed Pharmacist Prescribers



October, 2025

This paper has been guided by and prepared on behalf of the Advanced Pharmacy Australia (AdPha), Pharmaceutical Society of Australia (PSA) and Pharmacy Guild of Australia (PGA) as the *Joint Pharmacy Organisations*.

The Joint Pharmacy Organisations welcome the Pharmacy Board of Australia's initiative to develop a national endorsement for scheduled medicines prescribing by pharmacists, tasked to them by Australian Health Ministers. We support the Board's objectives of public protection, national consistency and workforce mobility, and believe the model set out in this paper aligns closely with the National Law.

The model proposed for Endorsed Pharmacist Prescribing by the Joint Pharmacy Organisations is:

Autonomous prescribing where a health professional undertakes prescribing of **any scheduled medicine** within their **individual, self-determined, documented and authorised scope of practice**, based on completion of an **accredited training course**, and delivered in **appropriate collaborative relationships** with the patient and all other members of the healthcare team.

We look forward to further collaborative engagement on the endorsement pathway, to ensure it meets the expectations of patients, pharmacies and pharmacists. The effective and equitable integration of pharmacist prescribers into Australia's primary health care system is critical to high quality patient centred care.



**The Pharmacy
Guild of Australia**

Acknowledgement of Country

We acknowledge the Traditional Custodians of the lands on which we work and meet. We acknowledge Aboriginal and Torres Strait Islander culture as the oldest continuing culture in the world.

Aboriginal and Torres Strait Islander Peoples never ceded sovereignty, and we recognise the impact colonisation continues to have on the health of Aboriginal and Torres Strait Islander Peoples to date.

We acknowledge Aboriginal and Torres Strait Islander Peoples for their continuing connection to culture, language and country; along with Elders past and present and the Ancestors who walk with Aboriginal and Torres Strait Islander Peoples every day.

Acronyms

ABS	Australian Bureau of Statistics
AdPha	Advanced Pharmacy Australia
Ahpra	Australian Health Practitioner Regulation Agency
APC	Australian Pharmacy Council
CPMP	Collaborative pharmacist medication prescribing
COPD	Chronic obstructive pulmonary disease
ED	Emergency department
ENT	Ear, nose and throat
GPs	General practitioners
HPPP	Health professionals prescribing pathway
LGA	Local government area
MBS	Medicare Benefits Schedule
OCP	Oral contraceptive pill
PDL	Pharmaceutical Defence Limited
PBS	Pharmaceutical Benefits Scheme
PGA	The Pharmacy Guild of Australia
PPMC	Partnered pharmacist medication charting
PPMP	Partnered pharmacist medication prescribing
PSA	Pharmaceutical Society of Australia
UTI	Urinary tract infection

Contents

Joint Pharmacy Organisations' Paper for Endorsed Pharmacist Prescribers.	1
Acknowledgement of Country	2
Executive Summary	5
Recommendations	6
1. Background	8
1.1 Current Practice	9
2. What does this proposal change	13
2.1 Proposed Updates to Standards and Guidelines	13
2.2 New Guidelines and Standards	13
Proposed Updates to Standards and Guidelines	15
New Guidelines and Standards	16
3. Value	16
3.1 Service Need	16
3.2 Evidence for Benefit	16
3.3 Potential Economic Impacts	21
3.4 Alignment with COAG best practice principles	23
4. Proposed Model of Prescribing	24
4.1 Key characteristics	24
5. Risk Management	26
6. Engagement With Other Health Professionals	28
7. Education	30
7.1 Existing Courses for Pharmacist Prescribers	30
7.2 Case for all pharmacists with the appropriate education and training to be eligible to prescribe	30
8. Readiness Within the Profession	31
9. Existing Examples & Scenarios	31
9.1 Victoria. Rural and Remote	31
9.2 Queensland Health Pilot of Pharmacist Prescribing	32
9.3 The Alfred Hospital	33
9.4 Tasmanian Government Pilot of Pharmacist Prescribing in Aged Care	35
9.5 International Example. Alberta Canada	35
Conclusion	36
Glossary	36
References	38
Attachment A	42
Attachment B	44

Executive summary

In response to the Health Ministers directing the Pharmacy Board of Australia ("the Board") to establish an endorsement for scheduled medicines for pharmacists under section 14 of the National Law, the Joint Pharmacy Organisations have prepared this paper as a joint position on the most appropriate model of pharmacist prescribing to be endorsed.

We acknowledge the significant work undertaken by the Board since 2018 in exploring pharmacist prescribing arrangements that ensure public safety, and the readiness of the profession through engagement with recent prescribing and scope of practice initiatives, including education, training and infrastructure.

National registration of pharmacists as endorsed prescribers would bring Australia into line with other jurisdictions such as the United Kingdom, United States, Canada and New Zealand where pharmacist-prescribing has been implemented for 20 years, and, based on evidence internationally and in Australia, results in improved patient safety, quality of care, better access and more efficient use of health system resources.

Several models of pharmacist prescribing are either fully implemented or in pilot around Australia based on state and territory authorisation of pharmacist prescribing and existing professional competence within the pharmacist workforce. These include autonomous prescribing examples in primary care and collaborative or partnered prescribing in hospitals and aged care. In all of these examples, pharmacists work closely with other members of the healthcare team and take a patient-centred approach to providing care. The appropriateness of this prescribing is safeguarded by taking account of and ensuring: prescriber competence and training relevant to the setting and patient cohort, including continuing professional development requirements, population and health system needs, sound regulatory and governance arrangements and accountability by the pharmacist for the services provided.

Pharmacist prescribing delivers measurable benefits for patients, governments and the Australian economy, with a cost-benefit analysis based on Australian data identifying significant financial benefits to the Australian and State and Territory Governments of at least \$600 million per annum and quality of life benefits for patients. In an economic evaluation of Victorian hospitals, the demonstrated savings of partnered pharmacist medication charting (PPMC) were \$726 per hospital admission. Current consultation costs in Queensland for patients receiving care in community pharmacy are significantly lower than most consultation

costs in general practice, and a report by EY Australia in 2024 showed significant productivity gains for the broader economy through improved access to health care for workers.

While advances in pharmacist prescribing in Australia to date have been significant, there is significant variation by jurisdiction and care setting. This proposal would provide a nationally consistent approach via registration endorsement through the Board and existing state and territory legislative mechanisms for recognition of endorsement for pharmacist prescribers, and is vital for ensuring consistency in legislation, terminology, and professional recognition for pharmacists as prescribers. The proposal would also ensure access to healthcare services is equitable for all Australian patients regardless of location or choice of practice setting. All pharmacists should be able to work to their full scope of practice regardless of care setting, optimising pharmacist ability to deliver high quality, accessible patient care and workforce mobility across settings in alignment with the objectives of the National Registration and Accreditation Scheme.

The model proposed for Endorsed Pharmacist Prescribing by the Joint Pharmacy Organisations is:

autonomous prescribing where a health professional undertakes prescribing of **any scheduled medicine** within their **individual, self-determined, documented and authorised scope of practice**, based on completion of an **accredited training course**, and delivered in **appropriate collaborative relationships** with the patient and all other members of the healthcare team.

Recommendations

1. That the Board proceeds with seeking an approval from the Ministerial Council for an endorsement of scheduled medicines for pharmacists
2. That the Board proposes that the **Endorsed Pharmacist Prescriber** may: administer, obtain, possess, prescribe, sell, supply, review and/or use Schedule 2, 3, 4 and 8 medicines
3. That the Board proposes that the endorsed pharmacist prescriber would be **registered as a Pharmacist with the Board with no conditions** (or undertakings relevant to this endorsement) having successfully **completed an Australian Pharmacy Council (APC) accredited course of study leading to endorsement** as an Endorsed Pharmacist Prescriber.
4. That the Board proposes that the Endorsed Pharmacist Prescriber would be able to prescribe autonomously, within the pharmacist's individual, self-determined, documented, and authorised scope of practice.
5. That the Board utilises the Joint Pharmacy Organisations input on the Registration Standard for Endorsed Pharmacist Prescribers ([Attachment A](#))
6. That the Board utilises the draft Decision-Making Framework for pharmacy provided by the Joint Pharmacy Organisations ([Attachment B](#)) to support the autonomous prescribing model
7. That the Board utilises the Joint Pharmacy Organisations' paper on Endorsed Pharmacist Prescribers (this document) as part of its consultation work
8. That the Board seeks Ministerial Council approval to support patient access to Pharmaceutical Benefits Scheme (PBS) subsidy for eligible medicines prescribed by a pharmacist in the implementation of the Endorsed Pharmacist Prescriber arrangement.

1. Background

For the past few decades, non-medical prescribers within healthcare systems globally have become increasingly important for ensuring access to quality care due to improved recognition of their scope of practice in an environmental setting characterised by health workforce shortages and increased health demands. Historically, medicines were primarily prescribed by medical practitioners but access to care is likely to be seriously compromised if Australia continues to rely on this model. For example, a supply and demand study by the Australian Government in 2024 found that the shortfall in the number of general practitioners (GPs) from baseline projections was over 800 in 2024, increasing to over 2,600 by 2028, and 8,600 GPs by 2048¹, and patients reporting unacceptable waiting times to receive GP care in numerous sources (ABS, 2023-24) (Australian Healthcare Index, 2025). Workforce pressures also exist in the broader Australian health workforce, with a shortage of 70,000 nurses faced by 2035 (Department of Health and Aged Care, 2024), and the Skills Priority List 2023 report showing that more than 4 in 5 health professional occupations were in shortage in 2023 (Jobs and Skills Australia, 2023).

Pharmacists are well-placed as non-medical prescribers due to their training and expertise in pharmacology, therapeutics, disease state management, pharmacokinetics, drug interactions, adverse effects and medication safety as well as legal requirements.² Internationally, pharmacist prescribing has been adopted in the United Kingdom, United States, Canada and New Zealand under varying models. A large number of studies have been conducted in Australia over the last decade to assess the safety and quality of pharmacist prescribing. These studies demonstrate that pharmacist prescribing is both safe and effective.³⁻¹⁰

This paper outlines the evidence to support the development of a pharmacist prescriber endorsement model under section 14 of the National Law. The Board ensures that only suitably qualified pharmacists are registered. Furthermore, the Board is responsible for developing registration standards, codes and guidelines for pharmacists and for managing notifications.

Prescribing as defined in the National Prescribing Competency Framework¹¹ is a dynamic process involving the steps of information gathering, clinical and shared decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine. In the Framework, domains of competencies for person-centred prescribing are supported by competencies of professional practice.

Figure 1.1. Prescribing Competency Framework Domains ¹¹

Person-centred prescribing process
Competency Area 1 Understand the person and their needs
Competency Area 2 Understand the management options
Competency Area 3 Explore, discuss and decide on a plan for medicines
Competency Area 4 Prescribe medicines and communicate the agreed treatment decision
Competency Area 5 Monitor and review the outcomes of treatment
Professional practice that supports prescribing
Competency Area 6 Prescribe safely and effectively
Competency Area 7 Prescribe professionally

1.1 Current Practice

Pharmacists in Australia are currently appropriately trained to provide a range of services: medication supply and dispensing, prescribing, medication reviews, disease management, medicine administration and ordering and interpreting laboratory tests. However, the ability to perform these practice activities to their full scope of practice generally requires additional State and Territory legislation or other authorisation or approval.

The Board cannot authorise pharmacists to prescribe. The authorisation to prescribe medicines is set out in state and territory medicines and poisons legislation. Granting authorisation to pharmacists to prescribe requires a decision by each state and territory government to change legislation in its jurisdiction.

However, there are existing mechanisms within each state and territory government legislation and regulation to operationalise an endorsement for scheduled medicines for pharmacists. Other professions like optometry, podiatry, midwifery and more recently nursing have all introduced endorsements for scheduled medicines. The addition of pharmacists to the list of those professions able to “prescribe” is therefore a relatively straightforward task with legislation and regulation already pointing to the National Law for other health professions.

There are various pharmacist prescribing models already established in routine practice, where pharmacists have proven competence in prescribing of a select range of medicines, for example vaccination, and more recently for urinary tract infections (UTIs). The impacts of these models of care have led all Australian State and Territory governments to proceed to the implementation of further expanded scope of practice programs for community pharmacists.

However, with the expanded scope activities, there is significant variability among jurisdictions in stage, extent and mechanism for the implementation. This leads to practice inconsistency for pharmacists and variation in access to services and care for patients, creating confusion for patients, particularly where there are major differences in practice expectations between geographically close localities (e.g. border towns).

Part of the not insignificant issue with the expansion has been the way in which pharmacists’ role in the prescribing of medicines has been legislated and regulated within our various jurisdictions. For example, while providing vaccinations is a clinical task that strongly aligns to the definition and competencies required to prescribe (in most cases structured prescribing), regulation and legislation may assign this as **administration**. Similarly, consulting with patients about UTIs and determining the appropriate treatment (structured prescribing) is considered in most regulation and legislation as **supply/sell**.

While these may seem to be “administrative” concerns, the practical issue is the inconsistency in which each jurisdiction has operationalised the “models” of care within their own regulation/legislation. The other obvious concern is the lack of visibility for pharmacists as professional prescribers, where clinical skills and competencies are being applied to patient care but are represented by terms such as supply/sell. It can cloud discussions about the capability of the profession to participate in and manage the prescribing role when this is embedded in the regulatory process.

The current situation in community pharmacy by jurisdiction is more fully described on the next page and summarised in Table 1.1:

Queensland has authorised community pharmacists to prescribe Schedule 4 medicines for 17 acute conditions under certain circumstances. Pharmacist management of chronic conditions, such as asthma and chronic obstructive pulmonary disease (COPD), will continue to be piloted until the end of June 2026.

Some preliminary findings on the pilot services confirmed that these services are increasing access for patients who otherwise might not have received the care they needed, and that no safety concerns were reported for services delivered across the pilots (T Nicholls, 2025).

Western Australia will implement a trial program for all acute and chronic conditions included in the Queensland pilot from 2026.

Northern Territory has implemented regulatory changes to enable expanded services from August 2025 for all acute and chronic conditions included in the Queensland pilot.

New South Wales has: Authorised pharmacists to sell and supply certain Schedule 4 medicines for a range of skin conditions without a prescription under certain circumstances, as part of a clinical trial. Work is underway to explore expanding this to include ear infections and minor wound management.

Approved NSW Health to expand community pharmacy scope of practice outside of a trial framework. Tertiary-level accredited training is being explored in partnership with NSW universities to support the delivery of an expanded scope largely aligned with the Queensland pilot from 2026 onwards (with the exclusion of asthma, COPD and cardiovascular risk programs pending the evaluation of outcomes of the Queensland pilot). Authorised university-trained pharmacists from Queensland to provide treatment for additional health conditions.

Victoria: Pharmacists are legally enabled under an authorisation to provide certain Schedule 4 medicines for a range of skin conditions in addition to treatment of UTIs, oral contraceptive resupply and vaccinations for travel, following a successful pilot. In May 2025, the Victorian Government announced additional common health conditions and wellbeing services will be introduced over the next two years, bringing the total to 22 new services pharmacists can offer.

An independent evaluation of the Community Pharmacy Statewide Pilot found that levels of patient satisfaction were consistently high, with 97% of patients rating the services as excellent or very good; and, from the more than 23,000 services provided in the first 12 months of the pilot, no safety concerns were reported (Victorian Department of Health, 2025).

Tasmania is expanding the role of pharmacists to include treatment of conditions such as ear infections, reflux, skin conditions such as shingles and eczema, rhinitis, and wound care.

South Australia released a consultation paper in September 2025 which proposes a new regulation to provide conditional authorisation for pharmacists to prescribe certain Schedule 4 medicines under specific conditions. This regulatory change will enable the Expanded Scope of Practice for Pharmacists Initiative which allows community pharmacists who have successfully completed the approved training and authorisation to treat a range of acute conditions in line with the Queensland pilot from January 2026.

In primary, secondary and tertiary healthcare settings, collaborative prescribing by pharmacists has been steadily implemented since 2012 and is featured in all jurisdictions except the Northern Territory with slightly different names; PPMC, Partnered Pharmacist Medication Prescribing (PPMP), Collaborative Pharmacist Medication Prescribing (CPMP). Collaborative prescribing by pharmacists in hospitals has required a combination of jurisdictional legislation, regulatory changes and/or authorities or exemptions granted by senior executive service.

Table 1.2 on the next page summarises current services in hospital and institutional settings by States and Territories.

Table 1.1 Existing Full Scope Services and Prescribing in Community Pharmacy. Source: Pharmacy Guild of Australia 2025.

SERVICE	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Treatment of uncomplicated urinary tract infection ¹	✓	✓	✓	✓	✓	✓	✓	✓
Contraception service	✓ ₂	✓ ₂	✓ ₃	✓ ₃	✓ ₃	✓ ₃	✓ ₂	✓ ₃
Medicine management (therapeutic adaptation, substitution, continued dispensing)				✓		✓		
Acute exacerbations of mild plaque psoriasis	✓	✓	✓	✓	✓	✓	✓	✓
Acute wound management	✓	✓	✓	✓	✓	✓	✓	✓
Acute nausea and vomiting	✓	✓	✓	✓	✓	✓	✓	✓
Acute diffuse otitis media	✓	✓	✓	✓	✓	✓	✓	✓
Acute otitis media	✓	✓	✓	✓	✓	✓	✓	✓
Allergic and non-allergic rhinitis	✓	✓	✓	✓	✓	✓	✓	✓
Gastro-oesophageal reflux and gastro-oesophageal disease	✓	✓	✓	✓	✓	✓	✓	✓
Herpes Zoster	✓	✓	✓	✓	✓	✓	✓	✓
Impetigo	✓	✓	✓	✓	✓	✓	✓	✓
Management of overweight and obesity	✓	✓	✓	✓		✓	✓	✓
Mild to moderate acne	✓	✓	✓	✓	✓	✓	✓	✓
Mild to moderate atopic dermatitis	✓	✓	✓	✓	✓	✓	✓	✓
Acute mild musculoskeletal pain and inflammation	✓	✓	✓	✓	✓	✓	✓	✓
Oral health screening and fluoride application			✓	✓		✓	✓	✓
Smoking cessation			✓	✓		✓	✓	✓
Travel health		✓	✓	✓		✓	✓	
Asthma ⁴	✓	✓	✓	✓		✓	✓	✓
Chronic obstructive airways disease ⁴	✓	✓	✓	✓		✓	✓	
Cardiovascular risk reduction: hypertension ⁴	✓	✓	✓	✓		✓	✓	
Cardiovascular risk reduction: blood glucose management ⁴	✓	✓	✓	✓		✓	✓	
Cardiovascular risk reduction: lipid modification ⁴	✓	✓	✓	✓		✓	✓	

¹ Permanently implemented all States² Resupply of Oral Contraceptive Pill only³ Hormonal contraception initiation and resupply⁴ As part of Queensland Community Pharmacy Chronic Condition Management Pilot

Table 1.2 Existing Pharmacist Prescribing Services in Secondary and Tertiary Care. Source: Advanced Pharmacy Australia 2025

Pharmacist-led collaborative prescribing footprint around Australian hospitals by jurisdiction	Implementation
Victoria Settings: Emergency Department, Inpatients, Discharge (without PBS)	PPMC first implemented in 2012 and has since been expanded to over 25 hospitals with funding from the Better Care Victoria Innovation Fund.
Western Australia Settings: Emergency Department, Inpatients, Discharge (without PBS)	In 2025, WA Health internally signed off on progressing PPMP to support wider implementation and efficiency gains. WA Health has assembled a working group and appointed project managers. Prior to this, PPMC has been implemented in five major metropolitan hospitals since 2017.
Queensland Settings: Emergency Department, Inpatients, Discharge (without PBS)	In April 2025, Queensland Health made regulatory changes to enable CPMP, supporting a statewide implementation. This is a similar model to PPMC. Prior to this, PPMC had been implemented in a handful of hospitals.
New South Wales Settings: Emergency Department	In 2024, uptake of PPMC was progressed through local health districts and is a model of care supported by the NSW Ministry of Health. To date the majority of the 17 Local Hospital Districts have implemented PPMC in emergency departments.
South Australia Settings: Emergency Department, Inpatients	Since the end of 2023, PPMP has been implemented in all Local Health Networks. This built on the implementation of PPMC since 2021 which supported efforts to tackle ambulance ramping and support patient flow through the hospital.
Tasmania Settings: Emergency Department Inpatients, Discharge (without PBS), Outpatients (without PBS)	PPMC has been implemented statewide since 2020, after successful initial trials beginning in 2017.
Australian Capital Territory Settings: Inpatients, Discharge and Outpatients (without PBS due to lack of PRA)	PPMC has been implemented at Canberra Health Service since 2024.
Northern Territory	No implementation of collaborative prescribing due to pharmacy workforce shortages.
Private hospitals	No implementation of collaborative prescribing due to inability for pharmacists to prescribe pharmaceutical benefits for inpatients, where the PBS otherwise does apply when prescribed by medical practitioners.

2. What the Proposal Would Change

2.1 What would be new?

The Board's view is that autonomous prescribing by pharmacists requires additional regulation via an **endorsement for scheduled medicines**.

An endorsement for scheduled medicines must be approved by Ministerial Council. An endorsement of registration for scheduled medicines indicates that a registered health practitioner is **qualified** to administer, obtain, possess, prescribe, sell, supply, review and/or use scheduled medicines (for example, Schedule 2, 3, 4 and/or 8 medicines). The health practitioner must hold a qualification relevant to the endorsement (an approved qualification or substantially equivalent qualification) as set out in a registration standard approved by Ministerial Council.

The Board would develop the Registration Standard to reflect the scope of practice for the Endorsed Pharmacist Prescriber under section 14 of the National Law. This would outline that an Endorsed Pharmacist Prescriber may: administer, obtain, possess, prescribe, sell, supply, review and/or use Schedule 2, 3, 4^a and 8^b medicines. A Joint Pharmacy Organisations' point of view on the Registration Standard for Endorsed Pharmacist Prescriber including in-scope medicines has been provided at Attachment A.

An endorsed pharmacist would be required to:

- Be registered as a Pharmacist with the Board with no conditions or undertakings relevant to this endorsement.
- Have successfully completed an APC-accredited course of study leading to endorsement for scheduled medicines as an Endorsed Pharmacist Prescriber.

2.2 What existing arrangements are changed?

Under the National Law, the Board has no regulatory barriers in place for pharmacists to prescribe via a structured prescribing arrangement or under supervision within a collaborative healthcare environment. Prescribing under these models is reliant on state and territory medicines and poisons legislation to authorise pharmacists to prescribe and these are matters to be determined by state and territory governments. This will not change in the proposed model.

Many current models of practice in jurisdictions around the country have been implemented successfully as business as usual under these structures including pharmacist vaccination and UTI services.

Does this endorsement process affect current pharmacist services?

When the proposed endorsement for scheduled medicines pathway is operationalised and pharmacists can achieve qualification and authorisation to prescribe autonomously it will not have a material effect on the current opportunities for pharmacists to provide care through other prescribing pathways (structured/supervised/collaborative). It would enable jurisdictions to streamline their existing local approval process for Autonomous Prescribing (e.g. Queensland) by pointing their regulation to the National Law.

Table 1.3 Description of existing prescribing arrangements and proposed endorsement pathway

Prescribing activity	Prescribing activity	Notes
Prescribe* (new)	Autonomous prescribing (S4, S8) within the pharmacist's scope of practice	Note: No botulinum toxin or cannabis
Prescribe	Autonomous prescribing within a limited scope of practice -specific for community pharmacy pilot/s**	Example: QLD community pharmacy pilot (17 minor ailments/ common conditions + collaborative management of 5 chronic conditions)
	In a supervised prescribing agreement in a collaborative practice setting	Example: Partnered charting
	Structured prescribing using guidelines, protocols or standing orders	Example: UTI May be represented in jurisdictional regulation and legislation as supply or sell
	For non-prescription (S2, S3) medicines	May be represented in jurisdictional regulation and legislation as supply or sell
Adapt/manage	Make therapeutic substitutions	Example: substitution of atorvastatin for rosuvastatin
	Renew/extend prescriptions	Example: OCP
Adapt/manage	Medicines Vaccines	Most commonly structured prescribing (guidelines/protocols) May be represented in jurisdictional regulation and legislation as administer

*The availability of a national endorsement for scheduled medicines pathway will not replace other practice and models for pharmacists contributing to prescribing, however will provide a consistent and standardised mechanism for endorsement which will allow jurisdictions to move away from bespoke interim pathways.

**Several jurisdictions, starting with Queensland, have utilised pharmacist prescribing training accredited by the APC to support delivery of Autonomous Prescribing pilots within specified scopes.

Proposed Updates to Standards and Guidelines

The proposed updates to the Standard are to:

- Reflect the proposed endorsed pharmacist prescriber model
- Align and support cross-profession consistency, where relevant
- Link to the Boards' shared Code of conduct and existing Registration standards
- Keep the guidelines contemporary, informed by best available evidence, and using Quality Use of Medicines principles and the Prescribing Competency Framework (3rd Ed).

Updated versions of supporting documents would be required and it is noted that several pieces of work are currently underway that would achieve this outcome:

- APC is currently developing a **Pharmacist Capability Framework** for the Board. This will describe the entry to practice capabilities of newly registered pharmacists who are adaptable to future practice change. It will support the Board's regulatory functions including registration and assessment for entry to practice. The Capability Framework will also replace the **Accreditation Standards for Pharmacy Programs Performance Outcomes Framework** to support APC's accreditation functions.

While it is expected prescribing will be a key part of these capabilities (as will vaccination, administration of medicines, medication review and other patient-centred pharmacy services) the consultation process for this is underway with public consultation commencing in November 2025. Professional capabilities should complement the endorsement process and underpinning role of pharmacists in medicines use across all medicine Schedules.

- APC is updating the existing **Accreditation Standards for Pharmacist Prescriber Education Programs**, which were developed in 2023. There are three currently accredited courses and several more under consideration. Extensive consultation will be undertaken as part of this review. A review of the Accreditation Standards for Pharmacist Prescriber Education Programs **Performance Outcome Framework** and evidence guide will include enhancement of the areas of clinical reasoning and diagnostic process/ patient evaluation and assessment. The recently updated **National Prescribing Competencies Framework 2025** will be a key enabler of these.
- PSA will begin updating the **Professional Pharmacy Competency** document (National Competency Standards Framework for Pharmacists in Australia) in late 2025. The existing competencies document references the National Prescribing Competency Framework (Ed. 2). Mapping of competencies against the National Prescribing Competency Framework (Ed. 2) shows three gaps in:
 - » 4.3 Where prescribing relies on electronic (e.g., telehealth) or telephone services (e.g., verbal prescription or medication order), ensure compliance with relevant legislation, guidelines and policies;
 - » 5.5 Discuss with the person the benefits of a comprehensive medicines review where appropriate;
 - » Ensure the person's needs take precedence over all considerations in all prescribing decisions.
- The updated National Competency Standards Framework for Pharmacists will continue to apply to pharmacists following initial general registration, primarily for the purposes of: identifying or confirming individual scope of practice, maintaining specific competencies required to practise to expected professional standards, and identifying and completing continuing professional development for professional registration.
- The existing Ahpra and National Boards Shared Code of Conduct outlines the Boards' expectations about professional behaviour and conduct for registered health practitioners. In the context of the practitioner-patient relationship, practitioners have a duty to put the care of patients first and to practise safely and effectively. Maintaining a high level of professional competence and conduct is determined to be essential for good care.
- The existing PSA Code of Ethics outlines the pharmacist's responsibility for patient-centred care, collaboration with other health professionals, to act with honesty and integrity to maintain public trust and to practise under conditions which uphold the professional independence, judgement and integrity. A revised version of this document, due June 2026 will reinforce the required professional integrity for healthcare practitioners who are both prescribers and suppliers of a treatment, including of the medicine.
- As endorsement will interact with authorisations determined by each state and territory as set out in medicines and poisons legislation, the Board should work with state and territory governments to drive reform of disparate legislation to recognise and align with the endorsement.

New Guidelines and Standards

A new **Board Decision-making Framework for Scope of Practice** is required.

A draft Decision-making Framework has been developed for consideration in the Consultation. This document complements the existing Pharmaceutical Defence Limited (PDL) risk framework and is aligned with professional practice standards and guidelines. This framework holds Endorsed Pharmacist Prescribers accountable to the Board for their decisions around scope of practice.

3. Value

3.1 Service Need

A series of government reports and activities including, the Strengthening Medicare Taskforce (2022), Unleashing the Potential of our Health Workforce (2024) and the Supply and Demand Study: General Practitioners in Australia (2024) have pointed to demand outstripping supply of clinical care, particularly in primary care. This places pressures on hospitals and other clinical services.

For example, in 2023, Australia had 39,449 GPs who provided primary care services through Medicare. From 2018 to 2023, there was an increase of 2,533 GPs. Despite this growth, it remained insufficient to meet the healthcare needs of Australians, placing strain on both the health system and the current GP workforce. With an ageing population and higher incidences of chronic disease, the Australian community requires better access to medicines in community settings. There is also maldistribution of GPs across the country, particularly impacting rural, regional, and remote areas. Australia's health system operates on the principle that no individual or community group should face disadvantages when seeking health care services.¹

Data from the Australian Bureau of Statistics (ABS) on patients' experiences found access to primary care was suboptimal with only 66.4% of people reporting that they could always see their preferred doctor and 28% reporting waiting longer than they felt comfortable for a general practice appointment.¹³

A review of scope of practice in primary care in 2024 found that enabling health professionals to work to full scope of practice supports a stronger primary health care system.¹⁴ Furthermore, the literature and international experience suggest such reforms help address challenges in access to care and health system efficiency, related to maldistribution of health professionals in regional and remote areas or inequities in access related to socio-economic status, culture or other social determinants of health.¹⁴

Modelling undertaken by EY Australia on behalf of the PGA in November 2023 found that expanding the scope of practice for pharmacists to prescribe for certain conditions would benefit the patient, the health system and the broader economy. Specifically, this modelling predicted improved access for rural and remote communities, reduction in Emergency Department presentations and improved access to GP consultations (unpublished data provided by PGA).

In hospitals and other institutional settings, workforce shortages contribute to medication error, ambulance ramping, bed block and long waiting times for many procedures and outpatient clinics.¹⁵

Workforce Mobility and Professional Satisfaction

The current situation whereby State and Territory governments allow different prescribing rights for pharmacists limits the ability of pharmacist prescribers to work to their full scope of practice nationally. Taking a national approach to endorsed pharmacist prescribers will improve workforce mobility to meet community needs.

In hospital practice local credentialling at the hospital or health authority level also limits workforce mobility with pharmacists needing to recredential when they move from one health authority to another. A single, standardised national endorsement model will allow for optimal flow of pharmacists between workplaces and settings.

3.2 Evidence for Benefit

Many countries have introduced pharmacist prescribing over the past 20 years, including the United Kingdom, the United States, New Zealand and Canada. Prescribing in these countries occurs in a range of settings including primary care, community pharmacy, emergency departments, hypertension and diabetes clinics, mental health units, drug and alcohol services and residential aged care, improving access to quality care.¹⁶

Australian and international examples demonstrate a positive overall impact of pharmacist prescribing in a range of settings as well as for specific conditions.

Specifically, a systematic review of 47 studies of pharmacist prescribing in four countries (United States, United Kingdom, Canada and New Zealand) in 2024 found that:

- 13 studies provided evidence of improved access to medicines by increasing the proportion of eligible people receiving medicines, increasing the number of overall dispensed prescriptions or reducing time to receipt of treatment

- Studies demonstrated that pharmacist prescribers in community settings were accessible with pharmacist prescribers viewed by patients as easy to consult and convenient.

Earlier work by Poh et al¹⁵ compared patient outcomes in a hospital setting for pharmacist and doctor prescribers. The authors found in a systematic review that pharmacist prescribers had similar or better results for clinical outcomes such as blood pressure control, cholesterol levels, blood sugar levels and glycosylated haemoglobin, were better at adhering to warfarin dosing nomograms and made fewer prescribing errors or omissions.

Several studies including a recent scoping study⁴⁸ report collaborative prescribing has been implemented to address:

- High rates of error from standard medical prescribing in hospitals:
 - » In general medicine wards where collaborative prescribing is prevalent, 60% of patients have more than three medication changes.
 - » An evaluation of PPMP at Royal Hobart Hospital found a 94.3% error rate reduction compared to usual care and a 94.1% reduction for high and extreme risk errors.³²
 - Ambulance ramping, bed block and patient flow through timelier medication reconciliation, review and prescribing.
 - » At Royal Melbourne Hospital, implementation of collaborative prescribing in general medicine wards resulted in reduction in median length of stay from 146 hours to 125 hours.⁵⁰
 - » If 10% of 3.2 million public hospital inpatient stays were in general medicine wards, national implementation would return 287,000 public bed days back to the system.
 - Medical and pharmacy workforce shortages resulting in reduced medical capacity in the system. Collaborative prescribing by pharmacists unlocks capacity for medical practitioners in all stages of hospital care.
- In his report on scope of practice for non-medical prescribers, Professor Cormack¹⁴ found studies in various jurisdictions showed:
- Evidence of improved access to care through longer consultations, more information sharing, and appropriate care utilisation across professions like nursing, midwifery, pharmacy, physiotherapy.

- Evidence of equal or better outcomes in areas like chronic disease management, mental health and prescribing.
- Evidence of cost savings, with some studies showing lower total costs and prevention of unnecessary services.
- Evidence of increased access in rural/remote and medically underserved areas, and moderately improved workforce maldistribution in the short-term.

A Community Pharmacist Statewide Pilot (the pilot) commenced in Victoria in October 2023, which was designed to test an expanded role for community pharmacists. It allowed appropriately trained community pharmacists to provide certain prescription-only medicines (Schedule 4) and vaccines as part of the following services:

- Resupply of select oral contraceptive pills (OCPs) without a prescription for women (16–50 years).
- Treatment for uncomplicated UTIs in women (18–65 years).
- Treatment for herpes zoster (shingles) and flare-up of mild plaque psoriasis for people 18 years and older.
- Vaccinations for travel, as well as vaccinations for hepatitis A, hepatitis B, poliomyelitis and typhoid.

The pilot aimed to increase access to affordable, local primary health care.

An independent evaluation⁵² of the first 12 months of the pilot found:

- Pharmacists provided more than 23,000 services in the first 12 months of the pilot. During that time, no serious safety concerns were reported, and levels of patient satisfaction were consistently high.
- Patient reports suggest significant improvements in efficient use of health resources.



2,762

of 3,172 patients surveyed would have used a GP service **(87%)** if the pilot was not available.



147

of 3,172 patients surveyed would have visited a hospital emergency department **(5%)** if the pilot was not available.



126

of 3,172 patients surveyed would have not sought any treatment or care **(4%)** if the pilot was not available.

Other examples of evidence for the safety and quality of pharmacist prescribing include:

Antibiotic Prescribing

A systematic review of antibiotic prescribing by pharmacists found a low incidence of adverse events, high levels of clinical success and lower rates of antibiotic prescriptions compared with general practitioners.¹⁷

Asthma and Chronic Obstructive Pulmonary Disease (COPD)

A US study of high-risk, home-based patients with COPD found that pharmacists reduced hospitalisations from 76.7% to 45.3% and reduced exacerbations from 86.2% to 63.5%.¹⁸

Cellulitis

Systematic review of pharmacist prescribed antibiotics for acute cellulitis showed a high level of patient satisfaction and increased convenience in accessing care. There was no significant difference in time to resolution of symptoms compared with physician treatment.

Dyslipidaemia

A collaborative drug therapy agreement model of independent pharmacist prescribing in the US led to increased number of successful therapies for patients with atherosclerotic cardiovascular disease.¹⁹

Influenza

Collaborative programs of pharmacist-led treatment of influenza in the US showed pharmacists actively referred patients who required further care and that there was no evidence of poor prescribing practices.²⁰

Heart Failure

Implementation of a specialist pharmacist service for patients with heart failure found that the mean time to medication optimisation was 3 months (averaging one appointment/month) and the number of optimised doses of guideline-directed medical therapy, increased significantly from 8% at first appointment to 76% on discharge ($p < 0.001$).²¹

Hypertension

Pharmacists in the United Kingdom, Canada and England have improved management of hypertension through prescribing²², medication review²³, counselling and disease-management programs.²⁴

Uncomplicated Urinary Tract Infections (UTIs)

\$51 million in reduced health care expenditure if 25% of Canadians with uncomplicated UTIs were treated by pharmacists over a five-year period.²⁵

A prospective registry trial of pharmacist prescription for UTIs in Canada reported on management of 750 patients. Clinical cure was achieved in 88.9%

of patients. Of those that did not have sustained symptom resolution, most (5.5% overall) had symptom recurrence after completion of therapy. Adverse events were reported by 7.2% of patients and 88.9% of those continued their medication. Most adverse events were gastrointestinal-related and transient. The patient satisfaction survey reflected very high levels of satisfaction for the care they received, as well as for trust and accessibility of the pharmacist.²⁶

Venous Thromboembolism (VTE)

Pharmacist-led prescribing of prophylaxis of VTE in surgical patients has been found to be effective in both tertiary referral hospitals⁸ and community hospitals.²⁷

Two models of pharmacist prescribing in an Australian hospital resulted in an increase in the proportion of patients receiving adequate prophylaxis for VTE for elective surgery and a decrease in the incidence of VTE resulting in cost savings and improvement in quality of life. The cost savings were \$12–\$31 per patient.²⁸

Pharmacist-led consultations

Since the introduction of registered pharmacist independent prescribers (PIPs) in England in 2015 there was an increased uptake from 2,224 in 2016 to 7,348 in 2020. Most of the practice-based pharmacist services are focused on medication reviews, management of long-term medical conditions and minor ailments, telephone consultations for follow-up and prescribing. Evidence from studies that involved patients with long-term medical conditions reported that pharmacist-led consultations could provide patients with better access to practice services and help reduce GPs' workloads, so enabling them to focus on patients with complex conditions.²⁹

General Medicine Hospital Wards

A cluster randomised controlled trial comparing PPMC to standard medical charting for patients admitted to general medicine units at a teaching hospital in Victoria was undertaken in 2015. The primary outcome was a medication error within 24 hours of admission. Of the 473 patients who received standard medical charting, 372 (78.7%) had at least one medication error identified, compared with 15 out of 408 patients (3.7%) in the partnered charting arm ($p < 0.001$). There were 175 high or extreme risk errors in the standard charting group, compared with one in the partnered charting group, with a number needed to treat to prevent one high or extreme risk error of 2.7 (95% CI, 2.4 to 3.1).³⁰

Further studies of partnered pharmacist charting undertaken in general medicine units at 7 metropolitan and 13 regional and rural public health services in Victoria ($n=8,648$ and 1,344 patients, respectively) reported significant reductions in the proportion of patients with at least one medication error on admission (65.9–66.7% with standard medical charting versus 3.6%–9.5% with partnered charting).

Median length of stay in hospital was shorter in the partnered charting group compared to standard charting in both studies (4.2 versus 4.7 days at metropolitan hospitals, and 3.7 versus 4.8 days in regional and rural hospitals; $p < 0.001$).^{10, 31}

Emergency Departments

Partnered pharmacist charting on admission has also been evaluated in emergency departments with similar reductions in medication errors observed when compared with standard medical charting.^{2, 32}

Hospital Discharge Prescriptions

A study of pharmacist prescribing on discharge for a 1,000-bed London hospital reported that pharmacists routinely wrote discharge medication orders as part of the clinical pharmacy service. The main outcome measure was the incidence of errors in pharmacist-written discharge medication orders. A total of 509 prescriptions, written by 51 pharmacists, containing 4258 discharge medication orders were assessed. Ten prescriptions (2%) contained a total of ten erroneous orders (order error rate 0.2%). A pharmacist reviewer considered that one error had the potential to cause temporary harm (0.02% of all orders). A physician reviewer did not rate any of the errors with the potential to cause harm.³³

Similar accuracy was found in a smaller Australian study of nephrology patients. Pharmacy-led partnered prescribing (PPP) resulted in a reduction of discharge prescriptions with at least one error reduced from 75.8% (usual care) to 6.7% (PPP) ($p < 0.001$). Discharge summaries with at least one error reduced from 53% to 24% ($p < 0.001$).³⁴

Other studies found partnered pharmacist prescribing on discharge in general medicine, surgery and aged care and renal medicine units had positive outcomes. These included significantly fewer discharge prescription errors,

reduced postoperative opioid prescribing, more accurate discharge summaries, and earlier ward discharge (57 to 110 minutes earlier), compared with standard medical discharge prescribing.³⁵

Oncology Services

In Alberta, Canada, oncology pharmacists utilise their independent prescribing to initiate and continue supportive care medications such as antiemetics for cancer patients.³⁶

A broader scoping review found a range pharmacist models described, including collaborative prescribing models (within protocols agreed with a physician), independent prescribing and supplementary prescribing (within a clinical management plan agreed by a physician and patient). All models demonstrated improvement in patient outcomes, adherence, and patient experiences (e.g., reduced time in clinic). Patients and physicians expressed initial reservation but were largely supportive. Pharmacists reported enhanced job satisfaction.³⁷

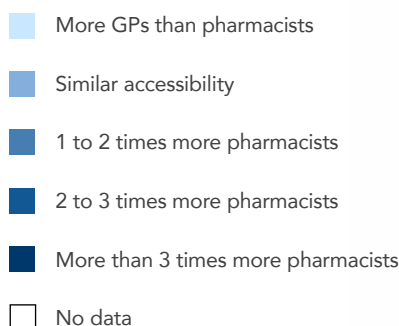
In Australia, PPMC was successfully scaled into cancer units as a collaborative medication safety strategy. The model was associated with significantly lower rates of medication errors, including for cancer therapies.³⁸

Accessibility of Care

Community pharmacy is a highly accessible healthcare service in Australia. In capital cities, 96% of people are within a 2.5km radius of at least one pharmacy. In the remainder of the country, 74% of people are within 2.5km of a pharmacy.⁴⁷ The comparative distribution of GPs and pharmacists is shown in Figure 3.1. This high accessibility has been shown in other jurisdictions to result in better or earlier access to care when pharmacists are able to prescribe.

Number of pharmacists compared to the number of GPs (per 1000 pop.)

Figure 3.1 Comparative distribution of general practitioners and pharmacists



Source: Prepared by EY, data provided by The Pharmacy Guild of Australia and authors of Savady, K., et al (2022), Structural Stigma and Sexual Health Disparities Among Gay, Bisexual, and Other Men Who Have Sex with Men in Australia. *J Acquir Immune Defic Syndr* 89 (3):241–250. Several regions are missing pharmacy availability information and for this reason the comparison is not available.

Acceptability

A systematic review of the evidence in 2020 found that pharmacists were motivated to prescribe, deriving increased job satisfaction and a sense of professionalism, particularly if adequately supported through appropriate programs of education.³⁹

Moreover, an earlier systematic review of both pre-implementation and post-implementation studies found favourable results.⁴⁰ Prior to implementation, support for pharmacist prescribing among patients was perceived as likely to improve access to health care and make better use of pharmacists' skills while also noting the need for additional training. Post implementation, the majority of patients who had experienced the service were highly satisfied with the consultation, particularly the pharmacist's competence and capability, considering their prescribing to be safe and effective.

The perspective of hospital medical and nursing staff on pharmacist prescribing has been notably positive. Studies^{35,41} found doctors and nurses acknowledge that pharmacist prescribing is beneficial in reducing medication errors and improving patient safety and flow. They also reported that pharmacist involvement in the prescribing process alleviated workload pressures and the benefits outweighed any risk of deskilling medical practitioners with the collaborative approach providing valuable learning opportunities. Junior doctors particularly appreciated this, noting that structured discussion with the pharmacist as part of the prescribing process enhanced on-the-job learning and supported workload management.

In Australia patients have generally reported high satisfaction with pharmacist prescribing including in:

- Community pharmacy⁴⁴
- Sexual health clinics⁴²
- Emergency departments.⁴

Acceptability of pharmacist prescribing is also being studied in Aboriginal and Torres Strait Islander communities⁴⁵ and recent work undertaken by PSA⁴⁶ reported:

Consumers recognise, trust and respect pharmacists as medicines experts. This trust exists with consumers individually, as well as their carers and family supports. Consumers value strong ongoing relationships with pharmacists on whom they rely for quality and safe use of medicines, quality care and medication advice. These relationships are founded on trust, accessibility, personalised and intergenerational care.

By and large, consumers are frustrated that pharmacists are prevented from prescribing medicines for common, non-complex conditions such as diabetes, blood pressure, asthma, urinary tract infections and skin complaints.

Some were aware this is changing under prescribing pilots in some jurisdictions, with several female participants indicating they welcome prescribing for hormonal contraception and urinary tract infections.

3.3 Potential Economic Impacts

3.3.1 Modelled savings to the Health System and Improved Use of Resources

A report by EY Australia on behalf of the PGA attempted to quantify the benefits of pharmacist prescribing for a discrete set of conditions (unpublished data provided by PGA):

- Uncomplicated UTIs
- Ear, nose and throat (ENT) infections
- Influenza
- Acute cellulitis
- Respiratory conditions: asthma and COPD
- Cardiovascular condition: dyslipidaemia
- Cardiovascular condition: hypertension
- Mental health conditions: depression and anxiety
- Administration of vaccines
- Non-vaccine injectables
- Travel medicines.

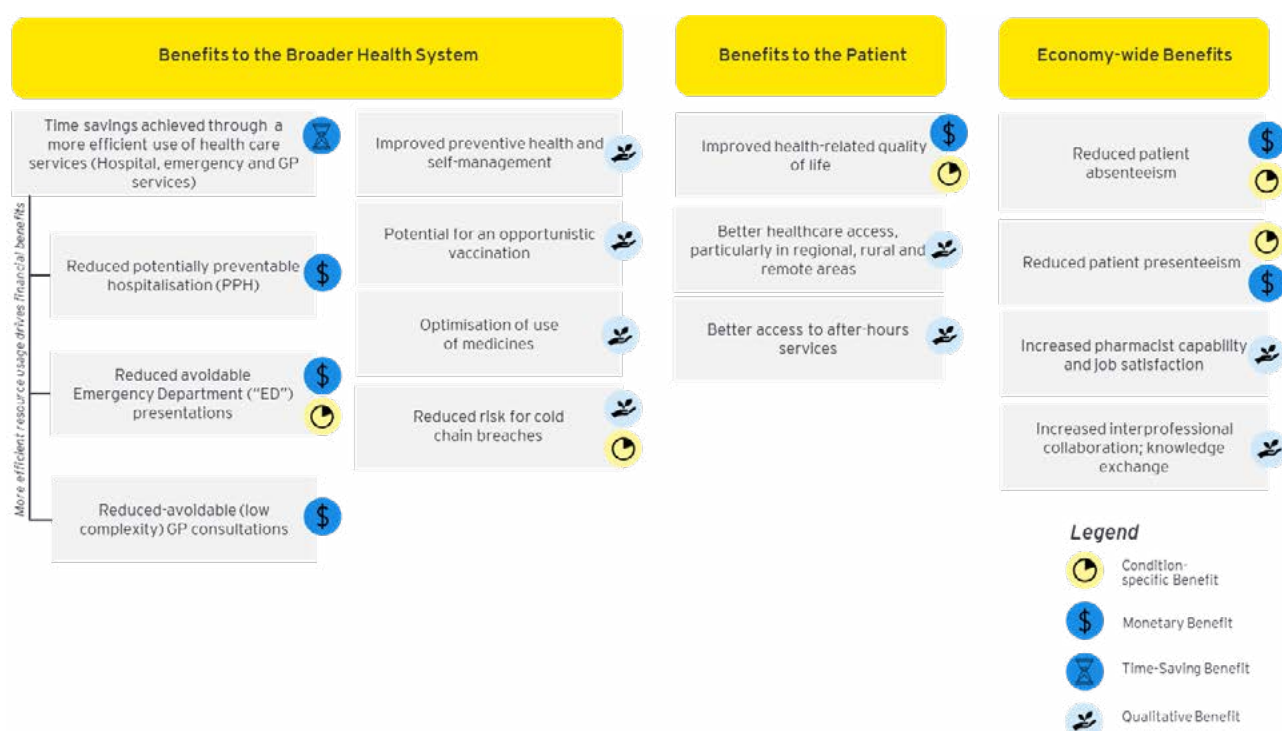
This modelling found that expansion of practice into the discrete set of conditions would generate a benefit of \$5.1 billion per annum, comprising:

- Annual healthcare cost-reduction benefit of \$401.2 million for the Australian Government
- \$219.8 million for State and Territory Governments
- Annual quality of life benefit of \$3.0 billion
- Total productivity benefits of \$1.5 billion from reduced absenteeism and presenteeism.

In addition, an expansion of practices into all conditions was estimated to generate substantial efficiency gains, comprising time savings of:

- 5,400,000 consultations in primary care
- 54,000 hours in emergency services
- 279,000 days in hospital care services.

Figure 3.2 Scope of Opportunity Assessment 2023. Taken from the EY Australia Report with permission



An economic evaluation of PPMC in Victoria undertaken by Deakin University demonstrated savings of \$726 per hospital admission and reduction in length of stay from 6.5 to 5.8 days and a cost-benefit ratio of 1:15.^{43,49} Extrapolation of this trial data to system wide implementation of PPMC across Australia could realise a 10.6% reduction in average length of stay and an estimated \$21.5 billion annual saving to the health system.

A cost, consequence and value for money scoping review of non-medical prescribing looked separately at pharmacist prescribing. While the number of studies available was small the results were broadly consistent. The study found that prescribing by pharmacists across a range of conditions, including venous thrombosis and hypertension resulted in significant improvements in health and clinical outcomes. In one study, this translated to a 30-year risk of cardiovascular disease being reduced from 0.61 in the base case to 0.41 (indicating a reduction of two cardiovascular events in every 10 individuals receiving the intervention). The intervention came at a higher cost than routine care, but the savings were approximately twice the increased cost.⁵¹

3.3.2 Cost to the Patient

The best estimated costs for patient-funded community pharmacy services are the Queensland community pharmacy chronic conditions management

pilots (<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/community-pharmacy-pilots/about>) where patients are required to pay the full cost of the consultation including:

- Consultation fee < 10 minutes \$19.50
- Consultation fee 10-20 minutes \$36.70
- Long consultation fee > 20 minutes \$70.50
- The cost of a private prescription
- The cost of any diagnostic, pathology or point-of-care tests.

Consultation costs are already significantly lower than most consultation costs in general practice, with only 56% of GP patients bulk-billed in 2024 and an average out-of-pocket cost of \$45 (RACGP, 2025). However, funding through the PBS for prescribed pharmaceutical benefits (medicines) and through the Medicare Benefits Schedule (MBS) for pathology services should be enabled for pharmacists to ensure patients can choose their preferred care setting while continuing to benefit from subsidised health care, including prescribed medicines counting towards their PBS Safety Net.

3.3.3 Cost to the Endorsed Pharmacist Prescriber

Pharmacists choosing to train as Endorsed Pharmacist Prescribers will be required to complete and pay for an accredited pharmacist prescriber course of study.

Accredited Pharmacist Prescriber course, for example, Graduate Certificate of Advanced Practice and Prescribing, offered by James Cook University is approximately \$12,000 for all units of study which would generally be completed over a 12-month period, including a five-day residential component held in Brisbane or Darwin. Universities in other states are likely to offer residential options in all major cities. In Queensland, Northern Territory, Western Australia, Tasmania, Victoria and South Australia, state governments are or have indicated their intention to subsidise education costs especially for rural and remote pharmacists.

The National Law provides that a registered health practitioner must not practise his/her profession unless appropriate professional indemnity insurance arrangements are in force in relation to the practitioner’s practice of the profession (section 129 of the National Law). Existing professional indemnity insurance providers have indicated readiness to extend indemnity to the broader scope of practice that includes prescribing which may impact the cost of insurance, although this has not been reflected in practice to date for pharmacies and pharmacists participating in jurisdictional scope of practice pilots.

3.3.4 Cost-Benefit to the Health System based on Australian Trials

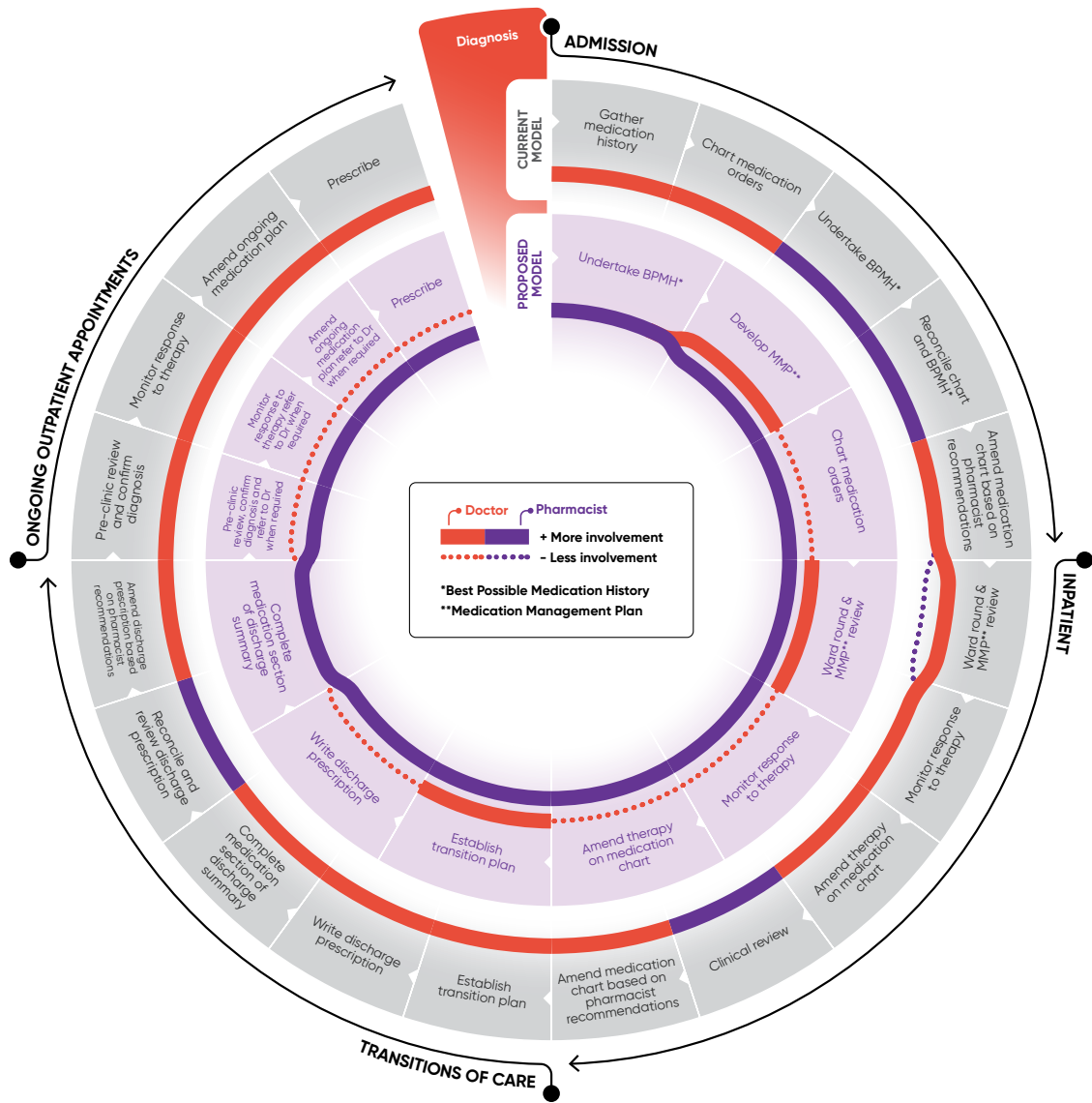
The overall cost to the health system is expected to be more than compensated by the savings generated by earlier access to medicines, fewer missed or delayed repeat prescriptions for medicines, and earlier treatment of common conditions. In New South Wales, extensions to pharmacist scope of practice have been modelled (EY Australia, 2024) to generate \$1.7 billion in savings per annum and time-savings benefits of:

- 1,760,000 consultations in primary care
 - 16,000 hours in emergency services
 - 97,500 days in hospital care services.
- Figure 3.3 summarises how these health system efficiencies can be achieved.

3.4 Alignment with COAG best practice principles

COAG has agreed that all governments will ensure that regulatory processes in their jurisdiction are consistent with the following principles.

Figure 3.3 Hospital Pharmacists Increasing Efficiencies in Patient Flow.
Source AdPhA 2025



Principle	Addressed
Establishing a case for action before addressing a problem	Yes
A range of feasible policy options must be considered, including self-regulatory, co-regulatory and non-regulatory approaches, and their benefits and costs assessed	Yes
Adopting the option that generates the greatest net benefit for the community	Yes
In accordance with the Competition Principles Agreement, legislation should not restrict competition unless it can be demonstrated that: a. the benefits of the restrictions to the community as a whole outweigh the costs, and b. the objectives of the regulation can only be achieved by restricting competition	Yes
Providing effective guidance to relevant regulators and regulated parties in order to ensure that the policy intent and expected compliance requirements of the regulation are clear	To be drafted by National Board following consultation
Ensuring that regulation remains relevant and effective over time	Yes
Consulting effectively with affected key stakeholders at all stages of the regulatory cycle	Will occur during consultation period

Source: COAG (2007) *Best Practice Regulation: A guide for Ministerial Councils and National Standards Setting Bodies*, October 2007, p.4.

4. Proposed Model of Prescribing

The proposed model for Endorsed Pharmacist Prescribing is autonomous prescribing where a health professional undertakes independent prescribing of any scheduled medicine within their individual self-determined documented scope of practice, which is based on completion of accredited training, and delivered in appropriate collaborative relationships with the patient and all other members of the healthcare team.

This model is part of the Australian HPPP, which standardizes the process for health professionals (excluding medical practitioners) to be able to prescribe medicines safely and competently. The overall purpose of the HPPP is to support a consistent, safe, and competent approach to prescribing by health professionals.

Key characteristics

- Autonomous Prescribing:** The defining feature of the autonomous prescribing model is the prescriber's ability to prescribe independently, without the direct involvement of another prescriber.
- Scope of Practice:** This autonomous prescribing must occur within the individual's professional scope of practice and competence.
- For Endorsed Pharmacist Prescribers,** the scope of practice will be influenced by the setting, the individual patient and the regulatory/governance arrangements. In practice this will mean that autonomous prescribing may occur in many settings, for example, community pharmacy, primary care, and within collaborative care teams in other healthcare settings such as hospitals, aged care, drug and alcohol services, mental health services and as part of hospital outreach services.
- National Consistency:** The HPPP provides a nationally consistent approach to prescribing for various health professionals, such as nurse practitioners and pharmacists.
- Contextual Application:** The models within the HPPP serve as guides for different prescribing approaches in various healthcare settings.

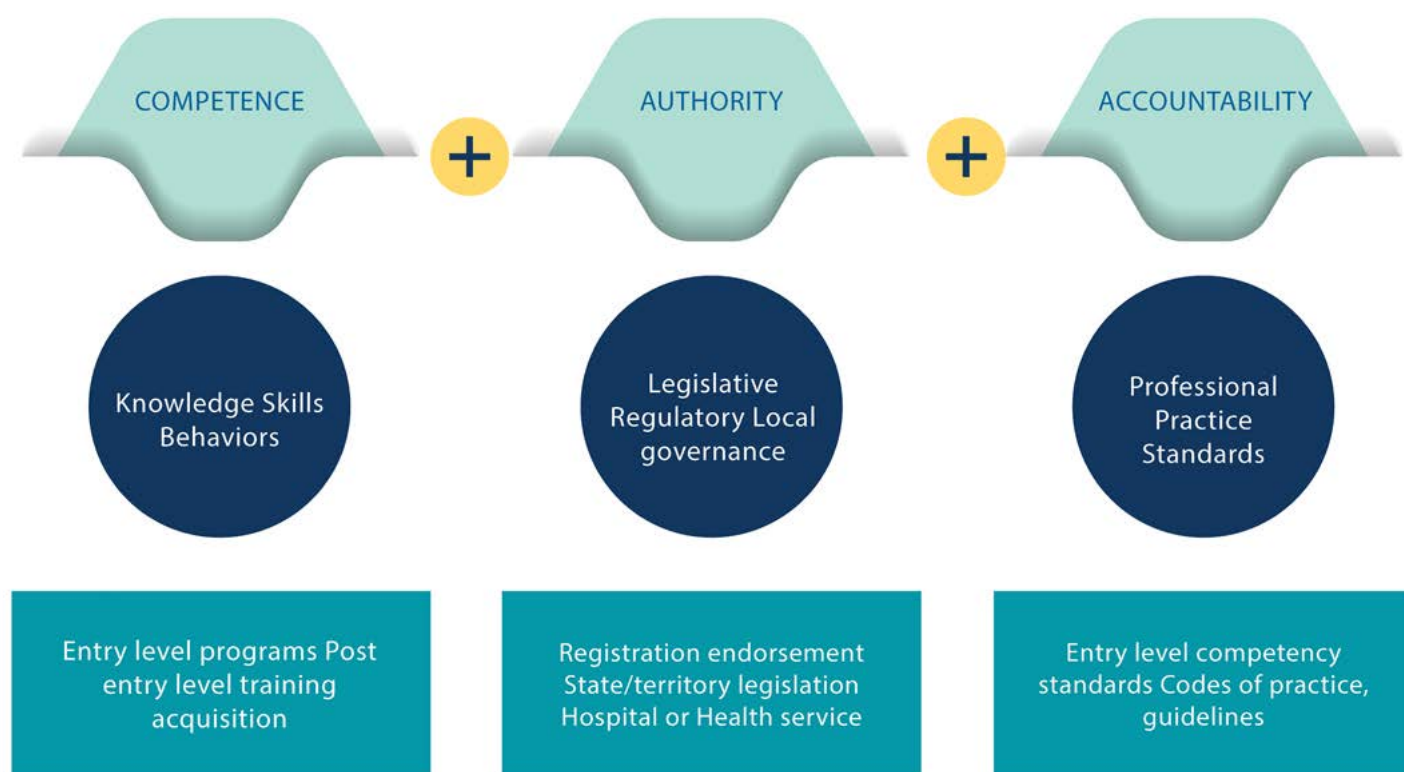
This proposal seeks endorsement to prescribe scheduled medicines within an individual pharmacist's scope of practice. In the short term, endorsement would occur following completion of an accredited pharmacy prescriber course by a practitioner holding general registration with the Board without restrictions, until integration of prescribing training and competency development into the threshold qualification has been completed. Following this integration, endorsement would occur for all graduates upon registration. The United Kingdom is moving to this model in 2026, with all graduates registering as prescribers (<https://www.hee.nhs.uk/our-work/pharmacy/transforming-pharmacy-education-training/initial-education-training-pharmacists-reform-programme/newly-qualified-pharmacist-pathway>), and Australian universities are currently considering options for integration to occur.

What is the Alternative Option?

The alternative option is the status quo with State and Territory Governments continuing to amend their Medicines and Poisons legislation to support pharmacist scope of practice for prescribing on an ad hoc basis. This model is the current approach in Canada and the United States for example, resulting in significant variation between jurisdictions, both in terms of uptake of service activities by the profession and access for the community.

Moreover, lack of national consistency has a negative impact on workforce mobility, contrary to the objectives of the National Registration and Accreditation Scheme and could result in inequities of access to quality care across the country. A study in five states of the United States looked at decentralised authority for pharmacist prescribing and found only those authorised by a pharmacy board and self-determined by the pharmacist (according to scope of practice) were effective in fully implementing pharmacist prescribing.⁵³

Figure 4.1 Scope of practice description⁴⁴



5. Risk Management

Non-medical prescribing has been shown to be of equal quality and efficiency to medical prescribing.⁵⁴ More recent data in Australian pilots of pharmacist prescribing have had similar results. In Victoria, a pilot of extended prescribing rights engaged 800 pharmacies which provided more than 23,000 services with 97% patient satisfaction and 0% serious safety concerns.⁵²

Successful implementation of non-medical prescribing has been found to be dependent on:

- Whole of system support (government, institutional and individual)
- Training
- Funding and policy settings.⁵⁵

The PSA has outlined several points⁵⁶ regarding the quality of pharmacist prescribing:

- Pharmacists have an established history of prescribing medicines consistent with their competency and scope of professional practice
- Safe, quality prescribing by pharmacists is supported by the implementation of rigorous, robust and responsive requirements with respect to training, assurance of competence, appropriate risk mitigation and authorisation to prescribe within an individual's scope of practice

- Prescribing and dispensing medicines are discrete clinical activities. Pharmacists possess the required foundation competencies to conduct both activities. Pharmacists, as with all health professionals, must address and manage any real or perceived conflicts of interest in their professional practice.

When a patient has multiple healthcare providers and prescribers, clear communication, integration of clinical records and clinical handover are essential elements of the service provided by health practitioners. Pharmacists are strong supporters of these practices.

Community pharmacy is also guided by the Australian Community Pharmacy Standard (AS 85000:2024) which provides the foundation for quality management of health care delivered through community pharmacy, including clinical governance and continuous improvement. Over 97% of community pharmacies are currently accredited against the standard.

The risk management framework in Table 5.1 summarises critical risks. Quality and safety of pharmacist prescribing would be regulated within the Board's regulatory oversight framework consistent with other pharmacy practice.

Risk	Likelihood	Potential Impact	Mitigation	Likelihood after Mitigation
Pharmacists not appropriately trained	Low	High	National regulation of prescribing pharmacists to ensure they are qualified, safe and competent to practise Ahpra National Prescribing Competencies Framework (3rd Ed.) APC accreditation standards APC Professional capabilities for pharmacists PSA Professional competencies for pharmacists (National Competency Standards Framework)	Low
Pharmacists not able to articulate scope of practice	Low	Medium	PDL Risk Management Guidelines PDL Scope of Practice Checklist Decision-making Framework for Scope of Practice PSA professional competencies for pharmacists	Low

Table 5.1 Risk Management Framework for Endorsed Pharmacist Prescriber Model

Risk	Likelihood	Potential Impact	Mitigation	Likelihood after Mitigation
Pharmacists not working within identified scope of practice	Low	High	• PDL Risk Management Guidelines • PDL Scope of Practice Checklist • Decision-making Framework for Scope of Practice • Ahpra Code of Conduct • AdPha and PSA Codes of Ethics	Low
Limited uptake	Medium	High	• Funding models for medicines (PBS) and medical tests (MBS) support pharmacist prescribing. • Government policies that support pharmacist prescribers • Support for undertaking an accredited pharmacy prescriber course. • Avoidance of unnecessary formulary restrictions • Integrate prescriber training into Pharmacy Degree Programs of study	Low
Pharmacists cannot access medical records	Low	Medium	• Patient consent to access. • PSA Professional Practice Standards • My Health Record	Low
Substandard communication between pharmacist prescribers and other prescribers leading to fragmentation of care	Medium	High	• Integration within digital clinical records facilitated through Australian Digital Health Agency supported initiatives • Clinical handover • Software to support clinical consultation and prescribing activity for pharmacist prescribers (e.g. MedAdvisor) • Ahpra Shared Code of Conduct (outlines expectations regarding interdisciplinary and inter-practitioner communication)	Low
Duality of interest resulting in prescribing of unneeded medicines	Low	High	• AdPha and PSA Code of Ethics • Ahpra Shared Code of Conduct • Healthcare complaint processes in each State and Territory Complaints to the Board	Low

6. Engagement With Other Health Professionals

The Board expects pharmacists to practise safely, effectively and in partnership with patients, colleagues, and other health practitioners. Pharmacists are expected to use patient-centred approaches, informed by the best available evidence, and aligning with Quality Use of Medicines principles to achieve optimal patient outcomes.

Pharmacists have a responsibility to recognise and work within the limits of their skills and competence and refer a patient to another practitioner when necessary. This includes ensuring they have the equipment, expertise and skills necessary to practise safely and effectively.

As outlined in the Boards' shared Code of conduct, pharmacists must ensure good practice when working in a team or collaboratively with other practitioners within the healthcare system. Patient care is improved when there is mutual respect and clear, culturally-safe communication, as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's health professions.

The professional roles, responsibilities and referral pathways for collaborative practice arrangements, are best determined in individual cases based on location, resources, skill-base of local healthcare practitioners and patient choice. In any collaborative practice arrangement, patients must consent to the arrangement and be clearly informed about who is responsible and when they need to attend reviews with each practitioner.

The Boards' shared Code of conduct includes guidance on working with other health practitioners, collaboration, effective communication, informed patient consent, referrals, and Aboriginal and Torres Strait Islander health and cultural safety.

The Clinical Governance Guidelines of the PSA support pharmacists in performing these roles (Figure 6.1).

1.Partnering with consumers		
1(a)	Co-design	Consumers are actively engaged in the planning and design of the services and care they receive. Health consumers, their carers and pharmacists should be partners in the co-design of pharmacy services.
1(b)	Patient-centric	Service design & delivery considers and supports consumer participation. Pharmacy services should be patient-centric and designed around the health needs and preferences of individual consumers. Consumers should be empowered to actively participate in decisions about their care.
1(c)	Empowering consumers through health literacy	Consumers should be empowered to participate in their care through communication measures which enhance health literacy and support informed decision-making.
1(d)	Measuring and improving consumer experience	Pharmacy service providers should actively seek feedback on consumer experience as key indicators of health care quality. Pharmacy service providers should learn from consumer experience measurement and use it to drive improvement in quality and safety of care.
2. Governance, leadership and culture		
2(a)	Commitment to safety and quality culture	Pharmacy services should be supported by adequate resources and systems for the provision of safe, effective and sustainable pharmacy care, consistent with relevant evidence. Accountability for the safety and quality of pharmacy services should be jointly shared by pharmacists, funding bodies, management and consumers.
2(b)	Clinical leadership	Pharmacists, managers and funders should champion and model quality & safety values in behaviours and decisions. Clinical leaders within the practice setting and wider profession should engage with pharmacists and related staff on safety and quality. Safety and quality performance of pharmacy services should be actively monitored and reviewed.

Figure 6.1 Principles of Clinical Governance for Pharmacists (PSA 2018)

3. Clinical performance and effectiveness

3(a)	Scope and standards	Professional guidelines, standards, policies and procedures should guide quality and safety by describing the scope and provision of competent pharmacy services.
3(b)	Evidence-based care	Pharmacists should have access to and use appropriate evidence-based guidance, indicators, models-of-care, and data to inform clinical decisions.
3(c)	Transparency	The clinical benefits, risks and costs of pharmacy services should be transparent to consumers and stakeholders.
3(d)	Education and training	Pharmacists should be supported to maintain competence and develop professional skills to enable high performance for pharmacy services within their scope of practice.
3(e)	Measurement and monitoring	Clinical measures of pharmacy service effectiveness, quality and safety should be systematically measured, monitored and reviewed by pharmacists, management and funders, including through: * undertaking clinical audits * participation in research projects * supervision and management of pharmacist and staff performance.

4. Patient safety and quality improvement systems

4(a)	Risk management	Safety and quality in pharmacy services should be supported by risk management systems which have actively engaged pharmacists in their design. These systems should include: * policies and procedures to manage and minimise risk of patient harm * incident management, including near-misses * open disclosure.
4(b)	Adhere to codes, guidelines and quality systems	Pharmacy services should demonstrate delivery consistent with relevant industry codes, guidelines, standards and relevant policies and procedures.
4(c)	Continuous quality improvement (CQI)	Services should be supported by evidence-based, ongoing, and cyclical improvement activities which support enhancements in clinical outcomes and patient safety.

5. Safe environment for delivery of care

5(a)	Environment	Pharmacy services should only be conducted where equipment is fit for purpose and the environment supports safe and high-quality care that meets consumer needs.
5(b)	Cultural safety	Pharmacy services should be inclusive and only provided in an environment which is culturally safe and respects the cultural diversity of consumers.

7. Education

Pharmacists are already educated, trained, competent and authorised to prescribe a limited range of medicines without a prescription (viz. administer, supply and sell). It is not proposed that this new endorsement for scheduled medicines will affect this status, retaining existing services including vaccination and S2/S3 medicine provision in pharmacy, for example.

Pharmacists will be required to undertake an APC-accredited and Board-approved course of study aligning to the competencies outlined in the National Prescribing Competency Framework (3rd Ed.) in order to become an endorsed pharmacist prescriber. For the existing pharmacist workforce, this training can be undertaken through several available providers. Over time it is expected that entry to practice courses, including Master of Pharmacy and Master of Pharmacy (Extended) would include prescribing competencies as part of the core curriculum meaning graduates would not be required to undertake additional training.

7.1 Existing Courses for Pharmacist Prescribers

The APC provides accreditation for (and Board approves) courses of study for Pharmacist Prescribing for existing registered pharmacists. The existing accredited courses are provided by PSA, Queensland University of Technology and James Cook University. Monash University and the University of Newcastle have recently announced new courses. Additional courses are under consideration by APC. It is important to note that currently, in addition to completion of a prescribing course, a pharmacist may be required to complete additional clinical components or jurisdiction-specific requirements to be able to prescribe in practice.

APC is updating the existing Accreditation Standards for Pharmacist Prescriber Education Programs to take account of the latest version of the National Prescribing Competency Framework. PSA will begin updating the Professional Pharmacy Competencies (National Competency Standards Framework for Pharmacists in Australia) in late 2025. All of these pieces of work will support appropriate education of endorsed pharmacist prescribers.

The PPMC model which originated in Victoria has involved a formal credentialing process initially developed and provided through Alfred Health and now provided in partnership with Advanced Pharmacy Australia. The pre-requisites for pharmacists prior to undertaking the credential is that they have a minimum of two years clinical experience in a hospital setting with six months or more clinical experience in general medicine. Assessment includes an objective structured clinical

examination (OSCE) with medical and pharmacy involvement completed at the end of an experiential placement and completion of supervised cases.

7.2 Case for all pharmacists with the appropriate education and training to be eligible to prescribe

It is the pharmacy profession's view that all pharmacists with the relevant competency should be able to train as pharmacist prescribers. This is consistent with the United Kingdom model.

In 2024, the British General Pharmaceutical Council announced changes **to allow pharmacists to begin an independent prescriber course when they have the relevant experience and awareness.**

These changes replaced previous requirements for pharmacists to spend at least two years on the register before enrolling in a course and to have previous experience in a specified clinical or therapeutic area. Instead, applicants must have relevant experience in a pharmacy setting and be able to recognise, understand and articulate the skills and attributes required by a prescriber. This experience and awareness will act as the basis for their prescribing practice whilst training. It means current registered pharmacists and newly qualified pharmacists joining the register are able to begin an independent prescriber course when they have demonstrated readiness, including through experience gained during the intern year, rather than being limited to completion of requirements post-registration. The aim of the changes is to help meet the demand for more pharmacist independent prescribers from health services and patients, while focusing on competence in practice rather than time.

The standards for initial education and training of pharmacists from the UK General Pharmaceutical Council now specify: *during the foundation training year (intern year), trainee pharmacists will be expected to demonstrate learning outcomes specific to prescribing practice.*⁵⁷ This is consistent with their standards which are designed to produce adaptable pharmacists who are:

- Confident and capable of operating in multi-disciplinary teams across a variety of health care settings to meet diverse and changing patients' needs
- Dedicated to person-centred care. They will ensure high standards of quality use of medicines that incorporate both safety and effectiveness alongside compassion and empathy
- Proficient prescribers whose skills can be used to collaborate with and support the wider, complex healthcare systems.

Other jurisdictions also allow intern or trainee pharmacists to undertake prescribing courses. For example:

- Intern pharmacists in Ontario can take prescribing courses, but they must complete their registration requirements, including the supervised prescribing component, before they can practise prescribing independently
- Intern pharmacists in Ireland can do prescribing courses, as demonstrated by the design of the National Pharmacy Internship Programme (NPIP) which includes modules such as “Interprofessional Prescribing Science”.

8. Readiness Within the Profession

The uptake of pharmacist prescribing pilots (including business-as-usual models) and hospital-based collaborative prescribing models in the States and Territories has been strong. National bodies and educators are primed to support endorsed pharmacist prescribers as demonstrated by availability of accreditation standards, updates to guidelines, competency standards, codes of ethics and university curricula.

It is expected that the short-term uptake will be primarily in the existing cohorts of registered pharmacists who complete a post-professional-entry prescribing course.

Entry to practice courses, including Bachelor of Pharmacy, Master of Pharmacy and Master of Pharmacy (Extended) should include prescribing competencies as part of the core curriculum at the earliest possible time, meaning graduates would not be required to undertake additional training.

9. Existing Examples & Scenarios

Significant advances to pharmacist prescribing have been seen in Australia over recent years, however there is inconsistency in practice arrangements and patient access by jurisdiction and care setting. A nationally consistent approach via registration endorsement through the Board for pharmacist prescribers is vital to ensure access to health care services is equitable for all Australian patients and that pharmacists are able to work to their full scope of practice regardless of care setting, offering improved access to healthcare and workforce mobility in alignment with the objectives of the National Registration and Accreditation Scheme.

9.1 Victoria. Rural and Remote

Around 7 million people – or 28% of the Australian population – live in rural and remote areas, which

encompass many diverse locations and communities. These Australians face unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. Data show that people living in rural and



OUYEN PHARMACY

Alex Look is the pharmacist in Ouyen, a town of 1,000 people about an hour south of Mildura. A Multipurpose Centre is available in the town which relies on locum doctors for medical consultations. Alex saw the Victorian Pilot as an opportunity to better serve his community. Many of his patients are working women and to accommodate access he extended his hours into the evening when he would provide prescribing services. He reports that nursing and reception staff routinely refer patients who cannot be seen at the Multipurpose Centre to his pharmacy.

remote areas have higher rates of hospitalisations, deaths and injuries, and also have poorer access to, and use of, primary healthcare services, than people living in major cities. Medicare claims data from 2022–23 show that the number of non-hospital non-referred attendances per person, such as GP visits, were lowest in Remote communities and Very remote communities at 4.2 and 3.4 per person, respectively, compared with 6.6 per person in metropolitan areas.⁵⁸ Improved access to health care through pharmacists could alleviate the geographical barriers to care and promote improvements in health and life outcomes for these residents.

The Victorian pilot of pharmacist prescribing delivered more than 23,000 services in the first 12 months of the pilot. (Victoria Health Department, 2025) Women were the main recipients of care, receiving 84% episodes of care, which was expected due to the focus on prescriptions for UTIs and oral contraceptives. Over 90% of patients said they could access care within 24 hours, and this included patients in rural and regional areas. Specifically, the evaluation of the pilot found that it increased the healthcare options in regions where there was lower GP access than average.

- There was higher uptake of the pilot by pharmacies in 25 out of 49 Local Government Areas (LGAs) where existing access to primary health care was assessed as low. In these LGAs they had fewer GPs for every 1,000 individuals in a population when compared to the state average.
- Among the 25 LGAs where there was higher uptake of the pilot, 21 were located in regional or rural Victoria.
- The pilot performed strongly across nine of these 25 LGAs as more people received care for uncomplicated UTIs and resupply of OCPs than the average across Victoria. Seven of these were in regional or rural LGAs.

9.2 Queensland Health Pilot of Pharmacist Prescribing

Queensland Health is facilitating the delivery of the Queensland Community Pharmacy Chronic Conditions Management Pilot. The aim of this pilot is to improve access to high-quality primary healthcare services for Queenslanders, particularly for those in regional and rural communities.

Background

In 2022 the former Labor Queensland Government made an election commitment to work with the PGA, PSA, and other stakeholders to design and implement a pilot of pharmacists practicing to their full scope in North Queensland. The pilot's scope was determined following extensive research, planning, and consultation with key stakeholders, including consumer representative groups, and peak medical and pharmacy organisations. In September 2023, the pilot was expanded to the entire state, to improve healthcare access for all Queenslanders, regardless of where they live. The Queensland Community Pharmacy Scope of Practice Pilot officially launched on 24 April 2024.

Pharmacist Prescribing Practice

In March 2024 a separate training pathway was established for pharmacists to prescribe medication for hormonal contraception under a Queensland

Community Pharmacy Hormonal Contraception Pilot. Establishing a separate pilot enabled access to these services to be fast-tracked for women and girls across Queensland. This pilot was later permanently implemented. It includes medicines management services, hormonal contraception service, acute common condition services, and health and wellbeing services.

From July 2025, chronic conditions management services previously delivered under the Scope of Practice Pilot will continue as part of the new Queensland Community Pharmacy Chronic Conditions Management Pilot. Pilot services are being formally evaluated to determine how an expanded role for community pharmacists can assist to increase access to high-quality primary healthcare for Queensland communities. The pilot enables participating pharmacists to undertake prescribing as part of a chronic disease management program. The services available include:

1. Cardiovascular Disease Risk Reduction Program for type 2 diabetes, hypertension and dyslipidaemia
2. Improved Asthma (and exercise-induced bronchoconstriction) Symptom Program
3. COPD Monitoring Program.

In addition, from July 2025, pharmacists who have completed additional training and meet the requirements set out in the Extended Practice Authority – Pharmacists are able to provide clinical advice and treatment (which may include prescribing medicines) for the following:

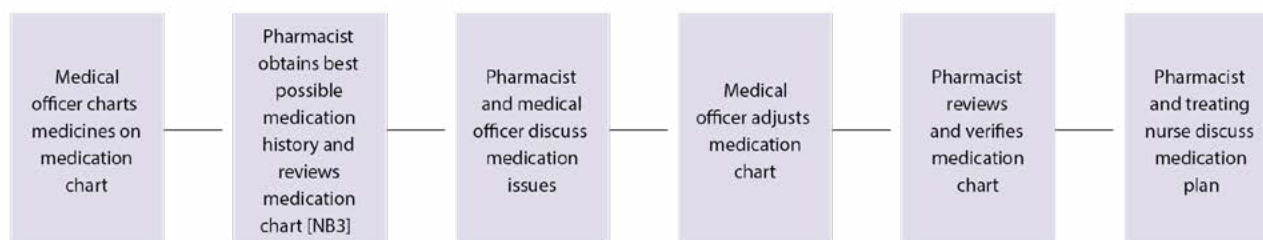
Gastro-oesophageal reflux and gastro-oesophageal reflux disease	Mild to moderate acne
Acute nausea and vomiting	Acute minor wound management
Allergic and nonallergic rhinitis	Acute diffuse otitis externa
Impetigo	Acute otitis media
Hormonal contraception	Acute mild musculoskeletal pain and inflammation
Herpes zoster (shingles)	Smoking cessation
Mild to moderate atopic dermatitis	Oral health screening and fluoride application
Acute exacerbations of mild plaque psoriasis	Travel health
Management of overweight and obesity	

9.3 The Alfred Hospital

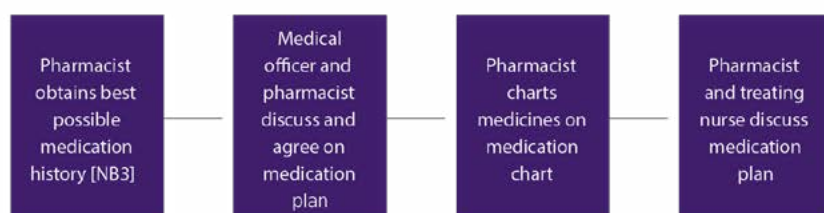
The PPMP is an innovative care model where appropriately credentialed pharmacists work collaboratively with authorised prescribers (e.g., medical or nurse practitioners) to undertake a medication review and chart medications for nursing staff to administer. This model which was developed in 2012 has been shown to reduce medication errors, length of hospital stay, and hospital costs.^{10, 35, 38,49} Starting in pre-admission clinics and supporting prophylaxis for venous thrombosis, the service has now been extended to all units in the hospital, including surgery, emergency department, intensive care, oncology, general medicine and critical events such as stroke and sepsis call-outs.

A comparison of the partnered medication and standard medical charts shows a more streamlined model.³⁵

Standard medical charting model



Partnered pharmacist medication charting model



NB1: These flow charts summarise medication-related processes only. In the partnered charting models there is no change to other medical officer tasks, such as gathering past medical history (which usually identifies some medicines) and undertaking clinical assessment and diagnosis.

NB2: In both models, the patient, and their carer where applicable, is included in decision-making and informed about their medication plan and changes to their medicines.

NB3: A best possible medication history (BPMH) is a comprehensive history of all medicines used by the patient, including non-prescription and complementary medicines, collated and verified using more than one source. A BPMH that involves the patient or carer provides the best assessment of the medicines a patient takes at home. It is the cornerstone of medication reconciliation and informs decisions about the medication plan.

TEN YEARS AT THE ALFRED HOSPITAL

Gail Edwards is Lead Pharmacist General Medicine at Alfred Health. She describes Partnered Pharmacist Medication Charting (PPMC) as standard care across the hospital. She works side-by-side with medical staff when a patient is being admitted to take a medication history and develop a medication plan which she then discusses with the patient and nursing staff. On ward rounds she documents changes to the medication regimen as a result of shared decisions with the wider team. Gail reports that being fully integrated into the team means she has been able to shift from a substantially reactive practice to being proactive, she is able to prevent problems rather than find and report on them after the event. She also noted that her understanding of how best to communicate her view to the medical team in a meaningful way has evolved with experience. Gail described her role in emergency stroke-call outs where she is responsible for traditional pharmacist roles such as taking a medication history and assessing when the last dose of thrombolytic medication was given. In the expanded role she is also responsible for checking there are no medication-related contraindications to thrombolysis, for recommending the dose of thrombolytic and charting medication to manage high blood pressure so that thrombolysis can be given as efficiently as possible. Gail said that she and her medical colleagues are continually learning from each other. She finds the role rewarding, being able to see the consequences of her care for patients and being part of a cohesive team. She noted that it would be unacceptable to move to a new role or health authority where she could not continue this expanded role, highlighting the need for a national approach if workforce mobility is to be achieved.

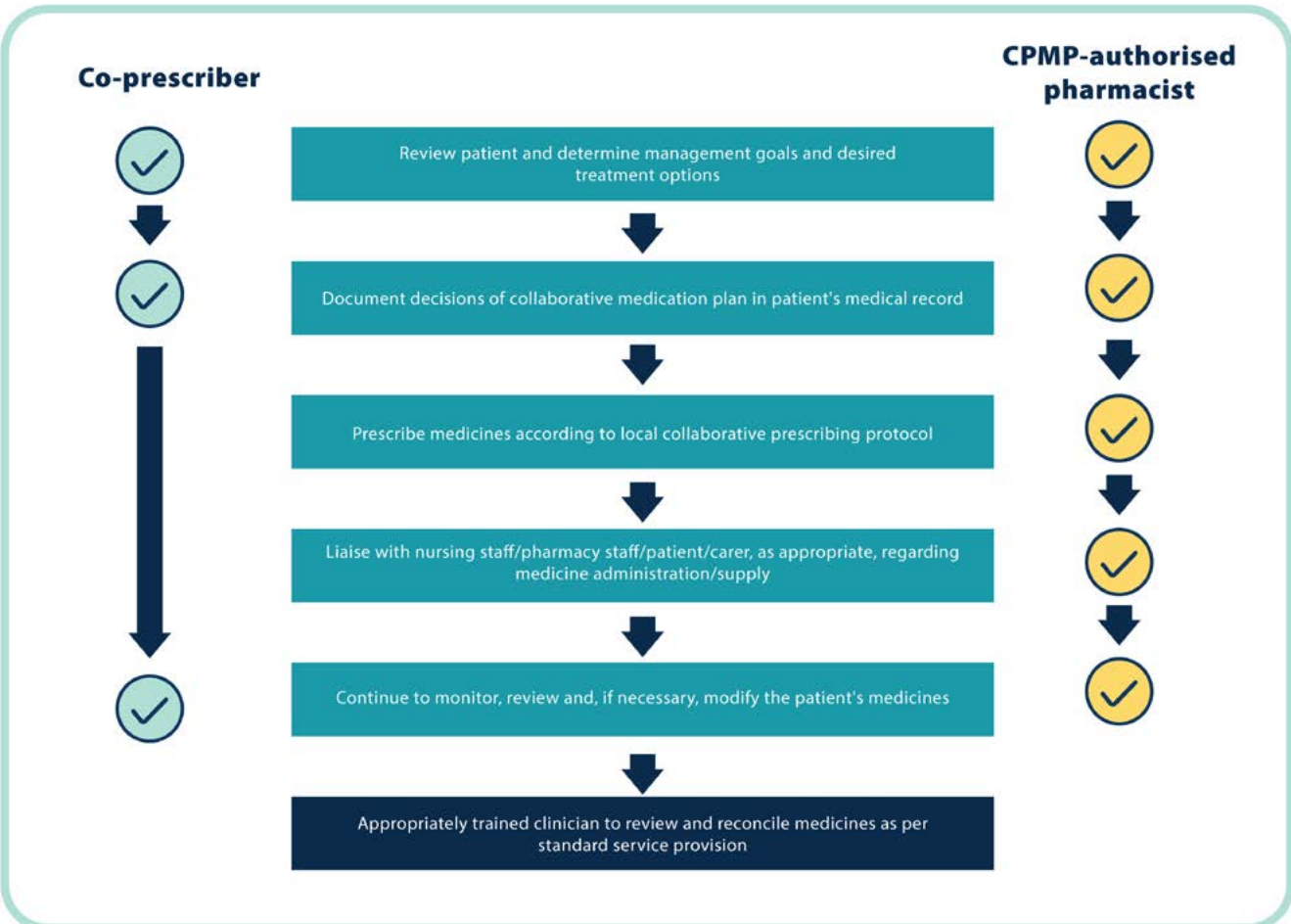
Queensland Health Collaborative Pharmacist Medication Prescribing

The CPMP model is a collaborative medication management process that involves medication review and prescribing of medicines. The Queensland process is important being the first state-wide approach to CPMP.

CPMP involves a CPMP-authorized pharmacist and a medical officer or nurse practitioner reviewing a patient’s medication and current medical issues and collaboratively agreeing on a management plan to optimise medicines. The CPMP-authorized pharmacist then prescribes the medicines according to the agreed plan for subsequent administration by nursing staff or supply to a patient.

Hospitals wishing to implement the model must develop a protocol that outlines the scope of prescribing (patient cohorts, settings, medicines and paper chart or system inclusions) and the governance arrangements. The overall collaborative process is described below.

Summary of the Collaborative Pharmacist Medication Prescribing Process



Note: If a medical officer or nurse practitioner and the CPMP-authorized pharmacist cannot reach agreement on a collaborative medication plan, they should jointly seek advice from a senior medical officer regarding the onward management of the patient.

9.4 Tasmanian Government Pilot of Pharmacist Prescribing in Aged Care

The Tasmanian government’s pharmacist prescriber model in aged care is a collaborative pilot program where GPs delegate prescribing authority to pharmacists to manage medications for residents according to an approved treatment plan. This model aims to reduce the burden on GPs and improve access to care for aged care residents by allowing pharmacists to prescribe necessary medications within defined parameters and a collaborative framework. The government is investing \$5 million for the training of pharmacists and the implementation of this program. This initiative is part of the government’s plan to increase the scope of practice for pharmacists to improve primary healthcare access across the state.

9.5 International Example. Alberta Canada

Alberta pharmacists have been able to prescribe since 2006 and have the most comprehensive authority of a province or territory in Canada. They can provide almost any medication except narcotics although only those with an Additional Prescribing Authorisation can initiate a new prescription-only medicine for a patient. Most prescribing pharmacists have been granted Additional Prescribing Authorisation.

In 2024, the Alberta government announced an expansion of private pharmacy clinics across the province as a significant relief valve for family doctors and emergency departments.

Pharmacist Prescribing in Alberta (The Health Professional’s Guide to Pharmacist prescribing. Alberta College of Pharmacy)

Clinical pharmacist who has completed the orientation			
Adapting a prescription (Effective April 1, 2007)			Prescribing in an emergency
Altering dose, formulation, or regimen	Therapeutic substitution	Issuing a prescription for continuity of care	Only when it is not reasonably possible to see another prescriber and there is an immediate need for drug therapy
Clinical pharmacist who has completed the orientation and has additional authorization under s16(3) of the regulation			
Additional prescribing authorization (Pharmacists will be able to apply for authorization to perform this function, pending ACP’s implementation of the evaluation process.)			
Prescribing based on:			
Pharmacist’s assessment at initial point of access, e.g., primary care	Collaboration with another authorized prescriber, e.g., chronic disease management		Collaboration with regulated health professionals who do not have prescribing authority

The model in Alberta has been well studied to show safe and effective prescribing by pharmacists in a range of conditions, including: managing hypertension²², heart failure⁵⁹, cardiovascular risk factors⁶⁰ and and diabetes.⁶¹

Pharmacists’ Scope of Practice in Alberta

Initiate Prescriptive Authority Schedule 1 medicines (i.e. prescription-only medicines)	Independently prescribe any Schedule 1 medicine
Adapt/manage Prescriptive Authority Schedule 1 medicines	Therapeutic substitution
	Change dosage, formulation or regimen
	Renew or extend prescription for continuity of care
Injection authority Subcutaneous or intramuscular	All medicines or vaccines
Laboratory	Order and interpret tests

A sub-study of patients who received cardiovascular risk reduction care, including prescribing, laboratory monitoring and follow up found the service was highly appreciated. When patients were interviewed by an independent third party, they highlighted that they valued the accessibility of pharmacists, their trust in and rapport with their pharmacist and the fact that pharmacists explained things well, supported them, were knowledgeable and provided excellent care.⁶²

Conclusion



There is a clear and demonstrable need in Australia for non-medical prescribers to be enabled, wherever possible, within their professional scope of practice given significant demand issues for the GP workforce, and the evidence supporting pharmacist prescribing being strong, showing pharmacists can be safe and effective prescribers. The profession stands ready, with high engagement with recent advances in autonomous and collaborative prescribing in some settings, but there is variation in authorisation across settings and jurisdictions, significantly limiting the value that pharmacists can deliver to the Australian healthcare system.

A nationally consistent approach via registration endorsement through the Board for pharmacist prescribers means all pharmacists will be able to work to their full scope of practice as pharmacist prescribers safely and effectively regardless of care setting, under a strong and consistent regulatory framework.

This would deliver better access to medicines for patients, and more efficient and effective use of healthcare resources and workforce in a context of health workforce need, including workforce mobility in line with the National Registration and Accreditation Scheme, while ensuring public safety.

Glossary

Accountability	Accountability means that pharmacists answer to the persons in their care, the Pharmacy Board of Australia, their employers and the public. Pharmacists are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their pharmacy role. Accountability cannot be delegated. The registered pharmacist, who delegates activities to be undertaken by another registered pharmacist, student, another health professional or health worker, remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.
Accreditation	A formal process of approval for a program of study or training that provides a person who completes that program or training with the knowledge, skills and professional attributes needed to practise their health profession or undertake that activity.
Autonomous Prescribing	Autonomous prescribing (one of the three models of prescribing described in the HPPP) occurs when a prescriber undertakes to prescribe within their scope of practice without the approval or supervision of another health professional. The prescriber has been educated and authorised to prescribe autonomously in a specific area of clinical practice. Although the prescriber may prescribe autonomously, they recognise the role of all members of the healthcare team and ensures appropriate communication occurs between team members and the person using a medicine.
Collaborative prescribing	Collaborative prescribing is a model where a pharmacist works with a medical practitioner or nurse practitioner to develop and implement a medication management plan for a patient. The pharmacist then follows this plan to prescribe and monitor medicines. This process involves joint assessment, shared decision-making, and shared responsibility for the patient's care.
Health Professional Prescribing Pathway	The Health Professionals Prescribing Pathway (HPPP) provides a nationally consistent approach to the prescribing of medicines by health professionals registered under the National Registration and Accreditation Scheme other than medical practitioners. The HPPP includes: principles for health professionals that prescribe, steps that a health professional must complete to undertake safe and competent prescribing, safe models of prescribing for health professionals and the roles and responsibilities in the HPPP.
National Law	Health Practitioner Regulation National Law as enforced by each State and Territory.
Schedule 4 medicines	Prescription Only Medicine in the Poisons Standard within the meaning of the Therapeutic Goods Act 1989.
Schedule 4D medicine (term used in some jurisdictions)	Prescription Only Medicine that does not have sufficient addictiveness or risk of abuse to be classified as Schedule 8, but for which significant addiction, abuse or diversion risk exists.
Schedule 8 medicines	Controlled Drug within the meaning of the Therapeutic Goods Act 1989.
Scope of practice	A time-sensitive, dynamic aspect of practice that indicates those professional activities that a pharmacist is educated, competent and authorised to perform and for which they are accountable. It is influenced by the settings in which they practise, the health needs of the people, the level of individual competence and the policy requirements (authority/governance) of the service provider.

Structured prescribing	Prescribing occurs where a prescriber with a limited authorisation to prescribe medicines by legislation, requirements of the National Board and policies of the jurisdiction or health service prescribes medicines under a guideline, protocol or standing order. A structured prescribing arrangement should be documented sufficiently to describe the responsibilities of the prescriber(s) involved and the communication that occurs between team members and the person taking medicine.
Structured prescribing	Prescribing occurs where a prescriber undertakes prescribing within their scope of practice under the supervision of another authorised health professional. The supervised prescriber has been educated to prescribe and has a limited authorisation to prescribe medicines that is determined by legislation, requirements of the National Board and policies of the jurisdiction, employer or health service. The prescriber and supervisor recognise their role in their healthcare team and ensure appropriate communication occurs between team members and the person taking medicine.

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Attachment A



Attachment A

Joint Pharmacy Organisations' Point of View on Registration Standard for Endorsed Pharmacist Prescriber Including In-Scope Medicines

1. An Endorsed Pharmacist Prescriber is qualified to independently **administer, obtain, possess, prescribe, supply, sell, review** and/or **use** Schedule 2, 3, 4 and 8 medicines within the standard and associated guidelines and relevant State and Territory legislation, for the purposes of the practice of pharmacy.
2. An Endorsed Pharmacist Prescriber must meet the following criteria:
 - 2.1 General registration as a Pharmacist with Pharmacy Board of Australia with no conditions or undertakings relevant to this endorsement.
 - 2.2 Successful completion of APC-approved (or substantially equivalent) units of study leading to endorsement for Scheduled Medicines as a Endorsed Pharmacist Prescriber.
3. In-scope medicines
 - 3.1 For all Endorsed Registered Pharmacist Prescriber: all TGA registered medicines within the individual's scope of practice and with the exceptions of items listed in Section 4 below.
4. Exceptions
Prescription of medicinal cannabis and botulinum toxin.

Attachment B



Decision-making framework for pharmacy:

A guide to practice decisions on scope of practice, delegation and supervision for registered pharmacists.

Introduction

The Pharmacy Board of Australia (PBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The PBA regulates the practice of pharmacy in Australia, and one of its key roles is to protect the public. The PBA does this by developing standards, codes and guidelines which constitutes the professional practice framework, and together establish the requirements for the professional and safe practice of pharmacists in Australia.

A DRAFT EXAMPLE Decision-making framework for pharmacy (the DMF) is provided as an evidence-based¹ contemporary document that would be used in conjunction with standards for practice, policies, regulations and legislation related to pharmacy.

Purpose of the decision-making framework

The purpose of the DMF is to guide decision-making relating to scope of practice and delegation and to promote decision-making which is:

- consistent
- safe
- person-centred, and
- evidence-based.

The DMF contributes to flexibility in practice and enables reflection on current practice and practice change.

The decision-making framework

The DMF consists of two parts:

1. Principles of decision-making, and
2. Pharmacy guides to decision-making that include the:
 - a. Guide to pharmacy practice decisions, and
 - b. Guide to delegation decisions

The PBA also provides the *Decision-making framework summary: pharmacy* as supporting guidance to be used in conjunction with the DMF.

The DMF provides guidance for registered pharmacists on:

- individual practice decisions
- expanding scope of practice, and
- when registered pharmacists can delegate aspects of care to others, such as other registered pharmacists, provisionally registered pharmacists, students, other health workers and pharmacy assistants.

Scope of practice

Registered pharmacists and provisionally registered pharmacists are responsible for making professional judgements about when an activity is within their scope of practice and, when it is not, for initiating consultation and collaboration with, or referral to, other members of the healthcare team.

Scope of practice decisions should be made in a collaborative way, through professional consensus, consultation and negotiation with the person, relevant family members and other members of the healthcare team.

Decisions about scope of practice should be based on considerations of:

- the person health status and any relevant social determinants to their healthcare
- lawfulness (legislation and common law)
- compliance with evidence, professional standards, and regulatory standards, policies and guidelines
- context of practice and the health service provider/employer's policies and protocols, and
- whether there is organisational support, sufficient staffing levels and appropriate skill mix for the practice.

Responsibilities for employers of pharmacists

Organisations in which pharmacists work must ensure there are sufficient resources to enable safe and competent care for the people for whom healthcare services are provided.

This includes policies and practices that support the development of pharmacy practice within a risk management framework such as the Quality Care Pharmacy Program.

The DMF establishes a foundation for decision-making that is based on competence and the provision of safe quality care. The substitution of health workers for pharmacists must not occur when the knowledge and skills of a pharmacist are needed. Under the National Law, pharmacists must not be directed, pressured or compelled by an employer to engage in any practice that falls short of, or is in breach of, any professional standard, guidelines or code of conduct, ethics or practice for their profession.

Using the DMF

Using the DMF in all practice settings

The DMF provides a consistent approach to decisions about pharmacy practice in all contexts. The DMF is most relevant for the clinical practice setting but may be modified or adapted for decision-making in other areas of practice. Pharmacy practice settings extend to working in a non-clinical relationship with people, working in management, leadership, governance, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the pharmacist's professional skills.

The DMF can be used:

- by registered pharmacists, and provisionally registered pharmacists when considering, determining and self-assessing their individual practice
- for purposeful engagement with employers, managers and policy-makers in interpreting, planning for and changing practice
- to initiate discussion about professional issues and to raise awareness in relation to scope of practice and decision-making
- to embed the principles and concepts underpinning the DMF within educational programs that prepare registered pharmacists and provisionally registered pharmacists for practice, and
- to identify practice that falls outside the accepted scope of pharmacy practice, or decision-making processes that are not consistent with the statements of principle in the DMF.

The DMF also provides guidance about how registered pharmacists and provisionally registered pharmacists delegate aspects of pharmacy practice. The DMF does not provide guidance regarding appropriate allocation or assignment of tasks.

Part one: Principles of decision-making

A set of principles underpin decision-making for pharmacy practice. The principles support the provision of safe, person-centred and evidence-based care and, in partnership with the person, promote shared decision-making and care delivery in a culturally safe and respectful way. Through the principles, and the guides to practice decisions based on them (Part two of the DMF), pharmacists are equipped to make decisions in a consistent way.

The principles that underpin decision-making for pharmacy practice are:

1. Pharmacists should make decisions about everyday practice, and changes to practice over time, that prioritise meeting the health needs of the community.
2. Planning, negotiation and implementation of practice change for pharmacists should be focused on meeting the health needs of the community.
3. Consent is gained from the person receiving care.
4. The promotion and provision of quality, culturally safe health services should be the drivers for change in practice, which should be made in partnership with the person and the broader community.
5. Pharmacists should integrate a comprehensive approach to managing risk into their practice to enhance safety and quality.
6. Evidence-based practice applies to all domains and contexts of pharmacy practice.
7. Changes to the practice of individuals or groups should be guided by:
 - the needs of and feedback from those receiving care
 - the evolution of new practice areas/capabilities, and
 - evolving health service needs.
8. When making decisions about practice change, pharmacists should consider the following determinants of practice and how they may limit or enable practice change:
 - legislated authority or restrictions on professional practice
 - professional standards of practice
 - evidence for practice
 - individual scope of practice (education, authorisation, competence and accountability for practice)
 - arrangements and decision-making in delegation, and
 - contextual/organisational support for practice.
9. The DMF forms part of the pharmacy professional practice framework and should be used when making decisions about practice change.

Part two: Pharmacy guide to practice decisions

Guide to pharmacy practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables pharmacists to work to their full scope of practice. The statements and actions set out below provide direction to pharmacists and other stakeholders about processes that will help to ensure that safety is not compromised when making decisions about scope of practice, about whether to delegate activities to others and for supervision support.

Statement	Action
The primary motivation for any decision about a care activity is to meet people's health needs or to enhance health outcomes.	Decisions about activities should be made: • in partnership with the person, supporting shared decision-making • based on a comprehensive assessment of the person and their health and cultural needs • only where there is a justifiable, evidence-based reason to perform the activity, and • after identifying the potential risks/hazards associated with the care activity and strategies to avoid them.
Pharmacists are responsible for making professional judgements about when an activity is beyond their scope of practice and for initiating consultation with, or referral to, other members of the healthcare team.	Judgements should be made in a collaborative way, through consultation and negotiation with the person, relevant family members and other members of the healthcare team. Decisions should be based on considerations of: • the person's health status and any relevant social determinants to their healthcare • lawfulness (legislation and common law) • compliance with evidence, professional standards, and regulatory standards, policies and guidelines • which is the most appropriate health professional to provide the education and/or competence-based assessment for the activity • context of practice and the service provider/employer's policies and protocols, and • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice.
Expansion to scope of practice occurs when a pharmacist assumes responsibility for an activity that is currently outside the pharmacists' scope of practice, or where an employer seeks to initiate a change, because of evaluations of services and a desire to improve access to, or efficiency of, services to groups of people.	Pharmacists planning to integrate activities that are not currently part of their practice should ensure: • the activity is within the contemporary scope of pharmacy practice and the relevant standards for practice would support the pharmacist performing the activity • there is no legislative basis that would prevent a pharmacist from performing the activity • they have any necessary authorisations, qualifications and organisational support to perform the activity • they have the necessary educational preparation, experience, capacity, competence and confidence to safely perform the activity • their competence has been assessed by a qualified, competent health professional or approved provider • that any identified risk has been assessed and if appropriate to proceed, mitigating measures have been adopted • consultation with relevant stakeholders has occurred, if necessary • the person receiving care consents to the activity being performed by a pharmacist who is undergoing training or expanding their skill set to include that particular activity, and • the organisation in which the activity is to be performed is prepared to support the pharmacist in performing the activity.
Registered pharmacists (the delegator) are accountable for making decisions about who is the most appropriate health professional or health worker to delegate to (delegatee) to perform an activity	Decisions about pharmacy practice should be made in partnership with the person whenever possible and to ensure that the right health professional or health worker is available at the right time to provide the care needs for the person. Decisions should be based on whether: the activity should be performed by a particular category of health professional or health worker • there is legislative or professional requirement for the activity to be performed by a particular category of health professional or health worker • the registered pharmacist has completed a comprehensive health assessment of the person's needs and determined that the activity can be delegated • the person has consented to the delegation of the activity, and re-consented to the activity being undertaken by the nominated delegatee • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the delegatee has been previously assessed by a registered pharmacist to ensure the activity will be performed safely • the delegatee is competent and confident of their ability to perform the activity safely, is ready to accept the delegation and understands their level of accountability for performing the activity • the appropriate level of clinically-focused supervision can be provided by a registered pharmacist for the delegatee performing an activity delegated to them, and • the organisation in which the registered pharmacist works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the delegatee performing the activity, and to support the decision-maker in providing support and clinically-focused supervision.

Statement	Action
Pharmacy practice decisions are best made in a collaborative context of planning, risk management, and evaluation.	Organisational employers/managers, other health workers and pharmacists share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of pharmacy practice • processes for providing continuing education, skill development and appropriate clinically-focused supervision, and • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and pharmacy practice decisions.

The pharmacy practice decisions summary illustrates the processes that a pharmacist would follow in making decisions about pharmacy practice, taking account of the statements set out above.

Guide to delegation decisions

Delegations are made to meet people's needs and to ensure timely safe and effective access to healthcare services. Delegation is a consultative, multi-level activity, requiring rational decision-making, consent from the various parties involved and a process of risk assessment. Delegation may only take place after education, where required, and an assessment of competence.

The delegation relationship exists when:

- a generally registered pharmacist (the delegator) delegates aspects of pharmacy practice in any practice setting to another person (the delegatee).

Delegation is different from allocation or assignment of tasks.

The delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes. The delegatee is unable to sub-delegate without referring back to the delegator. Provisionally registered pharmacists work as part of the multidisciplinary team, providing delegated care under the supervision of a generally registered pharmacist. This supervision cannot be replaced or substituted by another health professional.

The decision to delegate an activity to students should align with the educational goals in their program of study and demonstrated level of their individual knowledge and skill.

The delegatee is at all times responsible for their actions and is accountable for providing delegated care.

Generally registered pharmacists (delegators) play a key role in the coordination and delegation of care. Delegation of care should be made following a risk assessment by the generally registered pharmacist identifying the competence of staff.

Generally registered pharmacists are responsible and accountable for the coordination, supervision and delegation of/to provisionally registered pharmacists and others who assist them in the provision of care.

Delegation Phase	Actions
Assessment to determine appropriate delegation	The generally registered pharmacist (delegator) should conduct a risk assessment to determine appropriate delegation for the activity. Factors to be considered in making the decision include whether a pharmacist should perform the activity because: • the person's health status is such that the activity should be performed by a pharmacist because specific knowledge or skill is needed • professional standards indicate that the activity should be performed by a pharmacist • there is evidence that the activity is best performed by a pharmacist • any state/territory or Commonwealth legislation specifies that a pharmacist should perform the activity • any local or organisational policy, risk matrix, guideline or protocol requires a pharmacist to perform the activity, and • the model of care mandates that the activity should be performed by a pharmacist.
Responsibilities when delegating	To maintain a high standard of care when delegating activities, the generally registered pharmacist's responsibilities include: • a comprehensive, collaborative assessment of the needs of the person receiving care • an assessment of the knowledge, skill, authority and ability of the delegatee accepting the delegation • ensuring that the delegatee understands their accountability and is confident, willing and able to accept the delegation • regular review of the delegation, providing guidance, support and clinically- focused supervision • identification of potential risks/hazards and adoption of mitigation strategies, and • evaluation of outcomes of the delegation
Responsibilities when accepting a delegation	A key component of delegation is the readiness of the delegatee to accept the delegation. The delegatee has the responsibility to: • be aware of the extent of the delegation and the associated monitoring and reporting requirements • at all times, be responsible for their actions and accountable for providing delegated care • not sub-delegate without referring to the delegator • agree the level of supervision needed • seek support and direct supervision until deemed competent to perform the activity, and • participate in an evaluation of the delegation.
Delegation to a health worker or student	If the delegator decides that the activity can be performed by a health worker or student, the delegator will need to consider, within a risk management framework, and through professional consensus, who the most appropriate health worker or student is to perform the activity. In making this decision, the delegator will need to decide if: • performance of the activity by a health worker or student will achieve the desired outcomes, and the person consents, if possible, to the activity being performed by a health worker • there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a health worker. For students, support from the educational institution for this activity to be delegated to students should also be established • the health worker or student is competent (i.e. has the necessary education, experience and skill) to perform the activity safely • the health worker or student is ready (confident) to perform the activity and understands their level of accountability for the activity, and • there is a registered pharmacist available to provide the required level of supervision and support, including education

Definitions

These definitions relate to the use of the terms in this document and, where possible, align with definitions across other PBA publications. To note: Person/people is used to refer to those individuals who have entered a therapeutic and/or professional relationship with a pharmacist.

Accountability means that pharmacists answer to the persons in their care, the PBA, their employers and the public. Pharmacists are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their pharmacy role. Accountability cannot be delegated. The registered pharmacist, who delegates activities to be undertaken by another registered pharmacist, student, another health professional or health worker, remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

Activity/activities is a service provided to people as part of a pharmacy plan of care. Activities may be clearly defined individual tasks, or more comprehensive care. The term can also refer to interventions, or actions taken by a health worker to produce a beneficial outcome for a person. These actions may include, but are not limited to, direct care, monitoring, teaching, counselling, facilitating and advocating.

Code of conduct refers to the Ahpra and National Boards shared Code of conduct. There are other codes of conduct that also impact on the practice of pharmacists, other health professionals and health workers, including state and territory employer-based codes, and the National code of conduct for health care workers (for those who are not regulated by Ahpra).

Collaboration/collaborate refers to all members of the healthcare team working in partnership with people and each other to provide the highest standard of, and access to, care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe care.

Competence/competent is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability.

Competence assessment is the assessment of an individual's competence that may occur through structured educational programs or a peer review process. Evidence of a pharmacist's competence may include:

- written transcripts of the skills/knowledge they have obtained in a formal course
- their in-service education session records
- direct observation of their skill
- questioning of their knowledge base
- assessment from the recipient's perspective using agreed criteria, and
- self-assessment through reflection on performance in comparison with professional standards.

Comprehensive (health) assessment is the assessment of a person's health status for the purposes of planning or evaluating care. Data are collected through multiple sources, including, but not limited to, communication with the person, and where appropriate their significant others, reports from others involved in providing care to the person, healthcare records, direct observation, examination and measurement, and diagnostic tests. The interpretation of the data involves the application of pharmacy knowledge and judgement. Health assessment also involves the continuous monitoring and reviewing of assessment findings to detect changes in the person's health status.

Consent is a person's voluntary and informed agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved. Consent requires clear and easy to understand information, so that the patient is able to make an informed decision.

Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary healthcare team. **Context of practice** refers to the conditions that define an individual's practice. These include the: type of practice setting (such as healthcare agency educational organisation and/or private practice) location of the practice setting (such as urban, rural and/or remote) characteristics of care recipients (such as health status, age, gender, learning needs and culture) focus of pharmacy activities (such as health promotion, research and/or management), degree to which practice is autonomous, and resources that are available, including access to other health professionals.

Cultural safety concept was developed in a First Nations' context. This definition of cultural safety comes from the Ahpra Shared Code of Conduct and was developed for use in the National Scheme by the Scheme's Aboriginal and Torres Strait Islander Health Strategy Group in partnership with the National Health Leadership Forum.

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

Delegator is the person accountable (for this document it means registered pharmacist) for making decisions about to who is the most appropriate health professional or health worker to delegate.

Delegatee is a health professional or health worker who is delegated aspects of care or services.

Delegation is the relationship that exists when one member of the multidisciplinary healthcare team delegates aspects of care, which they are competent to perform and which they would normally perform themselves, to another health professional or health care worker.

Activities delegated by a registered pharmacist (delegator) to another registered pharmacist, provisionally registered pharmacist, student, another health professional or health worker (delegatee) cannot be delegated by that person, unless they have since obtained the authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that authority must consult again with a registered pharmacist.

Education includes formal education courses leading to a recognised qualification and informal educational methods include, but are not limited to:

- reading professional publications
- completing self-directed learning packages
- attending in-service education sessions
- attending seminars or conferences
- individual, one-to-one education with a person competent in the subject or skill, and
- reflection on practice alone or with colleagues.

Practical experience and assessment of competence by a qualified person are key components of any educational preparation for the performance of a care activity.

Evaluation is the systematic collection of evidence, measurement against standards or goals, and judgement to determine merit, worth or significance. It focuses on the persons response to pharmacy care to review the plan of care. It can also be used to determine the appropriateness of continuing to undertake an activity, or to delegate it. Relevant stakeholders who should be involved in evaluation including any party affected by the activity, such as other health workers.

Generally registered pharmacist - see Registered pharmacist

Health professionals are people who have the necessary education to qualify for registration in their respective professions, to provide a health service for which they are individually accountable. Information about health professionals who are nationally regulated is available at www.ahpra.gov.au. **Health workers** and others (also known as unlicensed healthcare workers) are any people who are not registered to practise under the National Scheme.

Health workers may have a care-worker qualification or no formal education for their role. Health workers are individually accountable for their own actions and accountable to the registered pharmacist and their employer for delegated actions. Routine activities requiring a narrow range of skill and knowledge may be delegated to health workers. An activity is routine if the need for the activity, the recipient's response and the outcome of the activity have been established over time and is therefore predictable.

Legislation/legislative refers not only to National Law, but also to a diverse range of state/ territory and Commonwealth acts and regulations that may affect practice.

Organisation/organisational support includes employers/organisations who are responsible for providing sufficient resources to enable safe and competent care for people for whom they provide healthcare services. This includes policies and practices that support the development of pharmacy practice to meet the needs and expectations of people, within a risk management framework.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a pharmacist. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the pharmacist's scope and context of practice.

Person-centred care is a collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred care recognises the role of family and community with respect to cultural and religious diversity.

Provisionally registered pharmacist is a person registered with the PBA who has completed the educational requirements determined by the PBA to enable them to undertake a period of supervised practice required for initial general registration in Australia pursuant to clause 52(1)(b)(i) of the National Law. This term also includes intern pharmacist.

Refer/referral involves a pharmacist sending a person to obtain an opinion or treatment from another health professional or entity. Referral usually involves the transfer (all or in part) of responsibility for the care of the person, usually for a defined time and for a particular purpose, such as care or treatment that is outside the referring health professional's expertise or scope of practice.

Registered pharmacist is a person who has completed the prescribed educational preparation including intern training program, and demonstrated competence for practice, and is registered by the PBA under the National Law as a registered pharmacist. The term also includes generally registered pharmacist.

Risk assessment/risk management consists of an effective risk management system, incorporating strategies to identify risks/hazards, assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur, prevent the occurrence of the risks, or minimise their impact.

Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual pharmacist may be more specifically defined than the scope of practice of their profession. To practise within the full contemporary scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. Decisions about both the individual's and the profession's practice can be guided using the DMF. When making these decisions, pharmacists need to consider their individual and their profession's scope of practice.

Student/s refers to those in programs of study that lead to eligibility to apply for provisional registration as a pharmacist. As part of their educational program, they are expected to provide care to people under the supervision of a pharmacist. Decisions about what activities a student may perform will be guided by consideration of whether:

- performance of the activity is congruent with the educational goals of the program in which the student is enrolled, and with the professional role that the student will undertake once they graduate
- the educational institution supports the performance of the activity by the relevant group of students, and
- the student is competent and confident to perform the specific activity for the person in the current context.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the pharmacist is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the shared Code of conduct.